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ABSTRACT

Articles by social work educators on some of the critical issues in community mental health are presented. Examined are some conceptual and program developments related to coordination, continuity of care, and the use of teams in planning and service delivery for community mental health (Lawrence K. Berg). The issue of civil commitment to and civil rights in inpatient facilities of persons diagnosed as mentally ill is addressed (Leila Calhoun Deasy). Some current issues for clinical social work practice in mental health are presented, considering programs of prevention, immediate, brief intervention, and long-term care (Patricia L. Ewalt). Two sets of guidelines for program evaluation in mental health are offered. One deals with judging the work of evaluators (Harris K. Goldstein) and the second is concerned with how mental health administrators can use the products of evaluation (James Proctor). Pointed out is the need to establish a rational and clear framework for social work practice in community mental health (Arthur J. Katz). Citizen participation is discussed as a means of maximizing the effectiveness of the service delivery program (Samuel O. Miller). The origins and applications of social work practice and education in primary prevention are also presented (Helen Reinherz). Deinstitutionalization and chronic mental patients are identified as related issues and part of a current and ongoing crisis for community mental health (Max Silverstein). (MSE)

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Community Mental Health

Issues for Social Work Practice and Education

EDITED BY

ARTHUR J. KATZ

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COUNCIL ON SOCIAL WORK EDUCATION

HE 012 069

Community Mental Health: Issues for Social Work Practice and Education

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Council on Social Work Education, 345 E. 46th St., N.Y., N.Y. 10017

Foreword

As Arthur Katz notes in his Preface to this volume, many social work educators have expressed concern that "too few materials written by social workers about social work practice [in community mental health] were available." The Council on Social Work Education is pleased to add *Community Mental Health: Issues for Social Work Practice and Education* to its growing list of publications on community mental health.

Social workers play an increasingly significant role in administering and providing community mental health services throughout the nation. Community mental health centers are settings for both practice and education. As field instruction sites, they are important resources for the preparation of generalist practitioners at the baccalaureate level and specialized MSW practitioners.

The chapters in this volume attest to the range of programs, philosophies, practice modes, and administrative structures that exist under the rubric of "community mental health." The authors have been particularly attentive to identifying implications for social work education and thereby for practice as well.

Because of the complexity of community mental health services, and the educational requisites for them, continuing examination of curriculum issues is essential. The Council is gratified to present this important book as an extremely useful contribution in its own right, and as a basis for continuing curriculum development work for teaching, learning, and practicing in the field of community mental health.

September 1979

GARY A. LLOYD
Executive Director
Council on Social Work Education

Preface

As a consultant to the Council on Social Work Education's Community Mental Health Practice-Education Project, I visited with faculty members in many schools of social work to learn how graduate-level social work education programs prepared students for the field of community mental health. Later, a formal curriculum study of that question was undertaken, a report of which was subsequently published by the Council. In these discussions, faculty members who taught courses related to community mental health raised the issue of the paucity of literature to support such coursework. They consistently expressed the concern that too few materials written by social workers about social work practice were available. With the exception of occasional articles in social work journals, the bulk of student reading assignments relating to community mental health was authored by psychiatrists and psychologists. This seems to be an anomaly, considering that social work professionals are so extensively represented in the community mental health system.

This publication is an attempt to bring together in one volume a series of articles by social work educators relating to some of the critical issues in community mental health for social work practice and education. It is hoped that such a publication will be helpful to professional social workers in the field as well as to students and faculty.

This volume does not purport to represent a comprehensive treatment of all significant issues facing the field of community mental health and the social work profession. Neither are the individual articles an exhaustive in-depth treatment of these issues. Rather, this book represents a selection of issues within the community mental health field that are considered to be of significant concern to social work practitioners. The authors have attempted to treat these issues from a social work practice perspective.

Lawrence K. Berg examines some conceptual and program developments related to coordination, continuity of care, and the use of team approaches in planning and service delivery for community mental health. He then discusses the implications of these developments for social work intervention and social work education. Leila Calhoun Deasy next addresses the issue of civil commitment to inpatient facilities of persons diagnosed as mentally ill. She discusses legal doctrines, judicial decisions, and state statutes that affect admission to, and discharge from mental hospitals, as well as the circumstances of institutionalized patients. Also examined are the effects of recent developments in mental health law on relationships between lawyers and mental health professionals. Finally, she projects and defines a role for social workers as mediators for patients.

Patricia L. Ewalt presents some current issues for clinical social work practice in the mental health arena. She considers programs of prevention, immediate, brief intervention, and long-term care, as well as discusses variations in service delivery that take into consideration ethnic, racial, and class differences. Implications for social work education related to these issues are suggested. Harris K. Goldstein and James Proctor offer two sets of guidelines for evaluation in mental health. The first deals with judging the work of evaluators, while the second is concerned with how mental health administrators can utilize the products of evaluation. Since federally funded community mental health centers are mandated to spend a small portion of their resources on evaluation, and since social work education programs are now beginning to give attention to program evaluation, the implications for social work practice obviously are present. Arthur J. Katz points out the need to establish a rational and clear framework for social work practice in community mental health and suggests an approach that may be utilized in developing a working frame of reference. The narrow interpretation of clinical social work practice in community mental health seems to constrain full development for the engagement of social work intervention. Also discussed are the choices posed in the medical practice model as against the human services model. A comparative schema is offered that may be helpful to conceptualize the role of social work practice. An approach to social work practice in community mental health is offered as one that retains the singular and special characteristic of professional social work. Implications for social work education also are discussed.

Samuel O. Miller focuses on one of the distinguishing characteristics of community mental health — citizen participation. When fully achieved, he argues, it maximizes the effectiveness of the service delivery program. Citizen participation is seen both as a process and a goal, and although professional direction of such activities is not the sole responsibility of social workers, social work has a special stake and competence in this area. He considers the historical perspectives as well as the current state of knowledge and practice in this area. He also presents suggestions for the teaching-learning area, as well as special implications for minority groups.

Helen Reinherz presents the origins and applications for social work practice and education in the concept of primary prevention. She reviews the current state of social work knowledge and practice in primary prevention, as well as the special skills being utilized in such programs, and discusses consultation, education, utilization of community and familial networks, and the implication of these programs for vulnerable groups. Specific recommendations for social work practice in education are offered.

Max Silverstein identifies the connected issues of deinstitutionalization and chronic mental patients as a current and ongoing crisis for community mental health. He suggests that social workers can play a vital part in overcoming this crisis, and points out that their unique contribution has been key to the entire deinstitutionalization process. The nature and genesis of the crisis is outlined and initial steps are suggested to deal with it. He identifies the professional responsibilities of social work practitioners and educators for developing processes of change in order to secure a more effective and comprehensive community mental health program.

It is hoped that this volume will be the beginning of a development which encourages the production of literature by social workers describing and defining social work practice in the all-important field of community mental health.

August 1979 ARTHUR J. KATZ

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Contents

FOREWORD iii

PREFACE v

I. Coordination of Services: The Interdisciplinary Team and Social Work Practice in Community Mental Health
by Lawrence K. Berg 1

II. Civil Rights of Mental Patients
by Leila Calhoun Deasy 16

III. Clinical Social Work in Community Mental Health Programs
by Patricia L. Ewalt 28

IV. Standards and Uses for Program Evaluations
by Harris K. Goldstein and James Proctor 42

V. An Approach to Social Work Practice in Community Mental Health
by Arthur J. Katz 52

VI. Citizen Participation in Community Mental Health Programs
by Samuel O. Miller 66

VII. Primary Prevention in Community Mental Health: Holy Grail or Empty Vessel?
by Helen Reinherz 78

VIII. Deinstitutionalization and the Chronic Mental Patient
by Max Silverstein 92

I

Coordination of Services: The Interdisciplinary Team And Social Work Practice in Community Mental Health

BY LAWRENCE K. BERG

Community mental health programs have become widespread over the last decade and a half. State and local mental health systems as well as individual private mental health agencies have begun to operationalize some of the ideas associated with a community mental health approach. One consequence of this movement has been a greater concern with the coordination of mental health and other social services, and collaboration of professionals in the mental health field. Service integration has become a desired condition in the human services. In community mental health, concern with coordination and continuity of care has resulted in interagency coordinated planning, the interdisciplinary team within an agency, and the use of teams to extend and coordinate community-based service.

This chapter will examine some conceptual and programmatic developments reported in the literature on coordination, continuity of care, and the use of the team approach to coordinate service and planning in community mental health. It will then turn to a discussion of the implications of these developments for both macro and micro social work intervention, and social work education.

The discussion will highlight the central role for the community-based interdisciplinary team as a way to enhance coordination and continuity of care as well as its use as a vehicle for social work education in community mental health. In addition, this chapter will underscore the importance of a dual focus for social work practice to help coordinate community mental health services. Social work practice needs to emphasize the macro intervention of community organization, planning, and administration, as well as the micro intervention of consultation, supervision, and clinical social work. The use of teams and the dual focus of practice present the practitioner and educator with various problems, some of which will be identified.

Coordination

Federal legislation that provides general guidelines to the community mental health efforts of many localities, as well as the various state mandates, make the mental health system responsible for providing a comprehensive and integrated network of services to a wide range of client groups. It appears that the legislative mandates for comprehensive continuity of care in mental health can be achieved through agency cooperation and coordination.

Community mental health programs can be viewed as multiservice programs using coordination—among other strategies—to make service more accessible to people.[1] Coordination to achieve a system of continuity of care is, of course, no simple task. Certainly our value orientation in human services highlights a concern for cooperation and coordination. Yet, in a practical sense, the human service arena historically has developed autonomous and often conflicting organizational structures to handle our mental health needs. Moreover, only recently have we begun the struggle to gain an understanding of what coordination is, what forms it can take, and what organizational variables affect its development.

In this discussion, coordination is viewed as the integration of the activities of two or more organizations,[2] the process of combining or relating different services across agency and program lines,[3] and the process of joint decision making among two or more organizations. A number of authors have examined coordination and its related concepts. These ideas have particular relevance to coordination in community mental health. Warren, explaining the dynamics of community decision-making organizations, distinguished among four types of contexts in which organizational units interact in coordinative efforts: (1) unitary, (2) federative, (3) coalitional, and (4) social choice. These are distinguished from each other on various dimensions, among them the organizational unit's relation to a goal, the locus of decision making, the locus of authority, structural provision for division of labor, and commitment to a leadership subsystem.[4] These types of contexts have particular value to community mental health systems with their wide variety of organizational arrangements.

Levine and White, in a study of health and welfare agencies, developed the idea of resource exchange as a dynamic around which coordination can take place.[5] In addition, we are alerted to the importance of organizational domain and domain consensus—the degree to which two agencies agree and accept each other's claims with regard to problems covered, services offered, and population served. These concepts were clarified further in a subsequent article by Levine, White, and Paul.[6]

In an often-quoted paper, Litwak and Hylton, after studies of the interorganizational arena through examination of community chests and social service exchanges, identified the importance of the interdependency of organizational units, awareness of the interdependency, and standardized units of actions. Furthermore, they made the distinction between the interorganizational field where coordination may be dependent on interdependency, awareness, and standardized units, and intraorganizational dynamics, where coordination may be more a function of a highly developed authority structure.[7] Both situations have relevance to community mental health networks—those with a highly centralized authority structure as well as those organized in more decentralized ways and relying heavily on the cooperation of different agencies.

In his attempt to synthesize the various theoretical approaches to coordination and analyze why it does or does not occur among autonomous agencies, Reid concluded the following: when interdependence among the agencies was high, attempts to coordinate them relied on a facilitating activity—liaison, mediation, and negotiation roles; when interdependence was low, coordination was dependent on activity to induce agencies to work together. Inducing agencies to coordinate can be achieved best if the coordinating agency has the resources and power to accomplish this more directive role.[8] This finding has special meaning to specific roles for social work in community mental health.

Continuity of Care

The mental health system, like many other human service networks, combines a concern for coordination with a focus on the importance of continuity of care in service delivery. Although a practical concern for the provision of integrated service has existed for some time, attempts to operationalize the tenets of continuity of care are relatively recent.[9] Continuity of care is "the relatedness between past and present care in conformity with the client's needs."[10] Furthermore, federal regulations in community mental health emphasize the ready transferability of staff, records, and clients.

Continuity of care refers to the coordination among various services that provides for a clients' treatment plan to incorporate the fact of their past relationship and experience with the service network. The concept of continuity of care also includes a component of flexibility in administrative procedures and policies that allows the focus to be on clients and their needs rather than on agencies and their boundaries, which hopefully reduces the possibility of clients getting "lost in the cracks" between agency boundaries.[11] Continuity of care is made up of five elements: links between all the patient's helpers, gaining the patient's cooperation in entering aftercare, providing the transition between settings or types of care, appropriate timing of contacts, and relating aspects of the patient's previous experience to the further care planned. It can be classified into continuity of personal relationships, continuity of services, continuity of program, and continuity with an organization.[12] Glasscote and his associates also made the distinction between continuity of therapist and continuity of responsibility.[13] However, the need for coordinated service is apparent under any of the definitions.

Problems with Continuity of Care

By itself, the recognized need to develop a coordination of services—a comprehensive, continuous care system—within mental health, has not resulted in its attainment. Some obstacles to continuity of care revolve around professional competition, professional image, and professional indifference.[14] Other obstacles appear to indict the actual organization of the mental health agencies. The existing organization still too often creates rigid boundaries between agencies, geographic boundaries limiting service, and different funding sources. This is made more difficult by the boundaries between the various and growing number of professions involved in mental health care. This is compounded even more by the growing recognition of the need to have many general social services integrated with mental health services.

Borus and his associates identified the neighborhood health center as a central point in the delivery of mental health services. The neighborhood health center's position makes it a particularly valuable place to integrate general health and community mental health systems to provide comprehensive and coordinated mental health care. However, in examining the ways these agencies coordinated services, the authors identified two major problems in linkages between different service providers: dual allegiances of the staff, and coordination of service within separately organized systems. Yet many of the centers surveyed did use interdisciplinary teams in an attempt to integrate and coordinate a wide range of services.[15]

The Interdisciplinary Team in Community Mental Health

The interdisciplinary team appears to be a common organizational arrangement used to coordinate services and provide a comprehensive and continuous care system. Pusic, in discussing cooperating systems in the administration of welfare, defined the team as a complex structure composed of specialists who function on the basis of equality among members. Further, teams are combined into networks on the basis of their mutual interdependence in function.[16]

The community mental health literature contains numerous references to the utilization of the interdisciplinary team as a vehicle to enhance an integrated continuity of services and accomplish coordination among different service units. In the model they developed for the delivery of mental health services through the use of a team approach, Dressler and Nash underscored the importance of social systems theory and small group process. The team approach is seen as having heuristic value as a conceptual framework for the organization of clinical teams and practical value as a guideline for the differential utilization of mental health specialists. The authors discussed composition, formation, roles, leadership, necessary skills, and authority in teams. They emphasized the need for flexibility and permeability of team boundaries and saw the interdisciplinary team as providing the mental health field with a training model for future mental health specialists.[17] The use of the team in professional training will be discussed later in this chapter. The team may be seen as a way of replacing the physician-dominated structure of inpatient care as well as a way of getting mental health professionals more involved in the patient's external community. Furthermore, at the administrative level, the team can meet the increasing need to share concepts and management plans.[18]

The team is seen as a vehicle to insure continuity of care as patients move back into the community. Coordination of various outpatient support services and inpatient care is facilitated through the use of a single team responsible for the client as an inpatient as well as the client as a member of the community.[19] The single interdisciplinary team approach to coordinating inpatient and outpatient care is particularly useful in situations where a single organizational authority has responsibility and resources for the inpatient and outpatient services. However, the interdisciplinary team also appears to have implications for the development of a coordinative effort among autonomous services. The use of decentralized community-based teams with linkages to boarding homes, churches, and other social agencies is a way of extending continuity of care, reducing duplication of service, enhancing accessibility, and reducing the need for transfers and referrals of patients between services.[20]

Problems Inherent in Teamwork

There is a growing effort to decrease the number of patients in large psychiatric hospitals. Parallel to these attempts at "deinstitutionalization" are efforts at linking state hospital units with decentralized community-based service systems. This trend has led to the increased use of community-based interdisciplinary teams. However, the movement toward the use of the team as a vehicle for coordinating a wide range of separate services has not been without some major problems. Some of them, although serious, have been humorously presented through a discussion of the different organizational forms that teams can take.[21] It is not possible in this paper to address all the problems inherent in teamwork, but it is worthwhile to mention a few that appear to be more relevant to our discussion of coordination and that have implications for social work practice.

New, in a detailed analysis of interdisciplinary teamwork in mental health, identified major assumptions underlying its operation. He pointed out that the assumptions providing a rationale for teamwork are seldom the ones that exist in "real" teams. The discrepancy between the actual assumptions and those that provide the rationale create "dissonance" and inhibit the team from optimal functioning. New provides us with examples: a significant assumption underlying the team approach is the equality of all team members. However, in reality members become aware of differential status and respond to each other based on this. Therefore the dynamics of the team do not reflect equality among members and the team finds it difficult to meet its goal of coordination of all services. A related problem exists when team members assume that one professional, because of his or her position, possesses a specific ability—leadership, for example—when in fact it is another team member who has the leadership skill. Again, if the team does not address the problem, its ability to handle internal administrative and coordinating tasks will be inhibited. In both these examples, the initial purpose of working in teams is subverted and the team becomes a microcosm of the uncoordinated service delivery the team was designed to alter.[22]

Connaway examined the place of the social worker-advocate on a team whose underlying framework is the implicit notion of a system characterized by sufficient equilibrium to carry out its task. One can see the team as needing substantial cooperation and agreement. Yet the client's interest may be served best if the social worker takes an advocacy position, which can be disruptive to the smooth running of the team. Therefore social workers with a strong commitment to client advocacy may find themselves in substantial conflict when working on interdisciplinary teams. Connaway suggested the need for a model of teamwork in community mental health that identifies constructive, legitimate, open, and accepted conflict as central to effective teamwork.[23]

Many of the discussions on coordination, continuity of care, and teamwork highlight the need for collaboration and cooperation. The smoothly running mental health system often is seen as identical with improved client care. The social worker appears to be seen as a neutral professional who is expected to bring, as are other mental health professionals, specific knowledge and skills to a more comprehensive team effort. The team operates with the subtle assumption that the self-interest of the various professionals, different organizations of the integrated health system, the community, and the client are one and the same. However, the interests of the different groups may not be the same. In fact the interests of one group may be directly opposed to those of another. In such a situation, the client may be served best through an advocacy role by one of the team members. Connaway's concern that client needs may be served best within a model of teamwork allowing for greater utilization of constructive adversary relationships and client advocacy has additional value to serving client interests in the broader integration and coordination efforts in mental health.

Although attempts to coordinate services, improve referral, and in general to utilize interdisciplinary teams in community mental health can be discussed, planned, and funded at the administrative-planning levels of mental health organizations, ultimate implementation of innovative plans and organizational structures is substantially dependent on the commitment of the mental health professionals at the line level. What these workers actually do—their behavior as they interact with one another and with clients—plays a large part in the successful operation of coordination. The positions they and their organizations publicly value and report often may be quite different from their actual behavioral interactions at the practice level. Recent studies focusing on the behavior of mental health specialists on community mental health teams highlight the importance of behavioral commitment to program goals. The data indicate that there are substantial discrepancies between attitudes and actual behavior of workers in aftercare planning and the referral process.[24] This is a particularly serious problem for coordinative efforts in community mental health.

Practice Implications for Social Workers in Community Mental Health

The increased emphasis on coordination of services, the renewed interest in learning about ways to operationalize continuity of care, and the growth in the use of interdisciplinary teams all have consequences for social work practice at both the macro and micro levels of intervention. Developments in social work practice in turn have direct implications for the knowledge, skills, and attitudes needed to carry out newly developing roles. Moreover, the demands on the social work curriculum to keep up with practice developments are increased. This is not to say that the process could not also go in other directions--from the schools to the practice arena.

Changes in Social Work Roles

Specific roles for social workers in the context of coordination, continuity of care, and interdisciplinary teams are closely tied to the changes of social work roles in community mental health in general. In addition to the more traditional clinical activities, agencies with a program orientation of community mental health use their staff in four ways: (1) to work with natural groups in the community, (2) to provide consultation to community caretakers, (3) to provide mental health information to the public, and (4) to help other community-based programs develop mental health resources.[25] The actual role of social workers in community mental health programs is substantially different from that of social workers in more traditional mental health settings. The differences center on the increase in community-based activity—particularly activity directed toward interorganizational planning for continuity of care and coordination of service units. Moreover, social workers can be expected to work with quite large interdisciplinary work units (teams).[26]

Extensive study of social workers in community mental health clearly indicates the need for them to be prepared for both direct clinical practice at a micro level of intervention and for a growing number of macro-level interventive tasks in administration, planning and coordination, community organization, and program consultation.[27] These findings are congruent with the positions of other authors who have identified two clusters of professional capability necessary for social work practice in community mental health: the first a clinical cluster, and the second the ability to provide community organization input.[28]

Macro Intervention: Implications and Problems for the Planner, Administrator, and Community Organizer in Community Mental Health

Let us turn first to the macro-intervention area (the administrative, planning, and community organization "cluster"). Levine, White, and Paul, in examining coordination and the concepts of resource exchange and domain consensus, identified specific implications for leadership and community organization tasks that have direct application to social work practice. These authors suggested six practice objectives: (1) realize the limitations in solving certain problems on the local level and where relevant, turn to the state or even national level to effect change; (2) improve the knowledge that organizations have regarding one another by making more explicit their goals, functions, problems, and restrictions; (3) recognize and analyze domain differences and related tensions between organizations, and develop mechanisms for the solution of these differences; (4) educate the boards and community leaders to recognize the interdependence of the health and welfare agency system; (5) address the personnel needs and reward systems of the various professions being coordinated; and (6) establish a formal mechanism by which specific professionals would be charged with the main responsibility for needs assessment and coordinating the activities of other agencies. This list presents social work administrators and community organizers with inter- as well as intraorganizational objectives in order to facilitate ultimately the resource exchanges that lead to coordination.[29]

In order to obtain the objective of coordination, the community-based team must address its own internal administrative and coordinative task. Osberg has identified the central importance of administrative and fiscal management in the operation of decentralized area programs. Program planning skills, supervisory responsibilities, budgetary processes, and staff training needs often are lodged in the decentralized team. The need for management expertise to carry out and coordinate the above tasks is a responsibility of social work education in community mental health.[30]

An additional role of importance for social workers in community mental health is that of community organization. At the macro-interventive level, the value of community organization skills in the planning and implementation of collaborative mental health programs has been reported in the literature.[31] Community organization knowledge and skills were found to be important for social work roles in community mental health.[32] Moreover, Levine, White, and Paul's practice approaches outlined earlier and the assumption of underlying coordination stated by Reid, and Litwak and Hylton reported above, all appear to suggest a large role for the community organizer in facilitating coordination in community mental health.[33]

Role Problems

In their commitment to accomplish interagency coordination, administrators often overlook the importance of the personnel needs and reward systems of workers. Social workers in community mental health may find themselves on large interdisciplinary teams working to create linkages between independent agencies and trying to coordinate a wide range of services. Work in the interorganizational arena is particularly subject to various types of role stress (role conflicts and ambiguities, for example). Community mental health settings, with their emphasis on interagency work, are more likely to engender role stress than are more traditional settings. Traditional settings have organizational boundaries that are more rigid and there is less concern for coordination with other community agencies. An investigation of social worker activities in community mental health lends considerable support to the belief that role stress is present among the staff—especially social work staff engaged in interagency coordination.[34] In addition to other practice objectives designed to facilitate the resource exchange and domain consensus necessary for coordination, the community mental health administrator needs to address the personnel needs of workers.

Other problems for social work mental health personnel revolve around the issue of organizational, professional, and personal allegiance. Is the team member accountable to the newly developing team, the employing organizational unit, or the profession in which he or she was trained? The authority structure within an independent agency or profession may be considerably clearer than that which exists when the agencies and professions come together in newer organizational units designed to coordinate services at the community level. We recall here the conflict of social workers who are engaged in coordinating efforts and who also take a client advocacy position. Intervention at the administrative and planning levels needs to address the above problems as the profession works toward coordinated planning and practice in community mental health.

Micro Intervention: Implications for Clinical Practice and Consultation

Combined activities in administration and community organization present the social worker with a wide range of roles—in addition to the clinical tasks of social workers in community mental health. Clinical social workers, under the auspices of the community mental health center, can find themselves providing direct service to clients in a wide range of other community agencies. Workers also will be working in collaborative arrangements with the staffs of these community agencies.

For example, the social worker can be expected to provide casework, groupwork, and services to families through existing agencies in the community. Aftercare, boarding homes, nursing homes, schools, correctional facilities, general hospitals, youth service agencies, and churches are just a few of the community agencies through which social workers in community mental health teams can address service needs. These are services that traditionally have been offered only through the direct connection of the client to the mental health agency, rather than through the client's linkage to another community-based service. In many of these cases, the social worker will be part of the decentralized interdisciplinary team discussed earlier. This type of arrangement will foster the growth of consultation as a role for the center staff. The use of teams to provide community consultation to a broad range of community agencies and programs has been described by Foley and his associates.[35]

In addition to consultation, the social worker with clinical skills can expect to be called on to provide supervision and training of other mental health workers, many of whom will have little or no formal professional education. Through a willingness to engage in these activities and others, social workers will help convey their commitment to working collaboratively. In some respects, the micro-level activities of direct service workers in different service organizations in community consultation, supervision, and training will be the ultimate test of the coordinated program efforts planned at the higher administrative levels. The referral processes, accessibility, and continuity of care appear to be partly dependent on the ability of a broad group of direct service caretakers working in coordinated teams.

Social Work Education in Community Mental Health

The material presented thus far has three major implications for social work education. The first centers on what the curriculum for community mental health practice needs to offer; the second revolves around the way the curriculum is designed and how it coordinates the use of interdisciplinary opportunities; and the third relates to the preparation of faculty and agency pesonnel for the education of social workers in community mental health.

Dual Focus of the Community Mental Health Curriculum

The wide range of knowledge and skills needed in community mental health presents the graduate school with a substantial challenge. This is especially so since data indicate that at least until recently the graduate curriculum in social work has not provided workers with adequate preparation for coordinative efforts in community mental health practice. Rather than graduate education, social workers rely upon on-the-job experience to learn many of the skills necessary for effective coordination of mental health service.[36]

Social work students planning to practice in community mental health need to have the knowledge and skills to carry out nonclinical, as well as clinical, roles. Preparation for nonclinical roles in administration and community organization at one level and in consultation, supervision, and staff training at another level has been found to be important to social workers practicing in community mental health.[37]

The dual focus for social work education implied here is not absent from the social work curriculum. The task for the educator is to be able to combine the two foci into a coordinated, comprehensive curriculum. One method of accomplishing this is through the use of the interdisciplinary team as a central vehicle for professional training. The functioning team can be the training ground for the professional in community mental health.[38]

The Team as a Training Vehicle

An outstanding feature of community mental health is its emphasis on coordination of different services and use of interdisciplinary team approaches. Yet education for social work practice (as well as for the other disciplines) in community mental health for the most part goes on in relative isolation. Educational programs in the different human services generally are uncoordinated. It is probably not uncommon to find in a single university setting separate training in community mental health for social workers, psychologists, psychiatrists, nurses, and counselors. Though some schools of social work have developed interdisciplinary training programs in community mental health, the predominant approach to education in community mental health focuses on a single profession. This type of arrangement does not lend itself to the demands for coordination that exist in the field.[39]

Interdisciplinary training offers the growing number of professionals in community mental health the opportunity to become aware of their unique contributions as well as their common knowledge base and skills.[40] However, the most promising aspect of interprofessional training centers on the attitudes of the professionals. Students trained together can be expected to be better able to collaborate later.[41] A first hand knowledge of each other's role and contribution can go a long way toward the development of mutual professional identification and respect that may be a necessary ingredient to effective coordination. Another advantage to the increased use of interdisciplinary training in the classroom and the field lies in the opportunity it provides for the first hand study of the small group dynamics of interdisciplinary teams. Improved knowledge and skills in this area will be useful in facilitating the effective use of teams in mental health delivery systems.

Continuing Education for Practitioners and Faculty

Social work education for community mental health is heavily dependent on the knowledge, skills, and experiences of faculty. The ability to coordinate the different aspects of community mental health training as well as the development of interprofessional education is tied closely to the availability of faculty and agency personnel willing to undertake this effort. Faculty and agency personnel also need to be acquainted thoroughly with the dual foci of knowledge and skills necessary for practice in community mental health. However, many educational programs for social work practice in community mental health do not have such personnel.[42] Continuing education programs for both agency personnel and faculty can play an important role in this area.

A further problem for education in community mental health comes from the need to bring into the curriculum knowledge around minority cultures and ethnicity. The need for this knowledge is particularly important as community mental health continues to coordinate mental health services in inner-city urban areas as well as rural areas. Students and professionals in mental health—who are themselves members of racial and ethnic minorities—may be particularly valuable in assisting to develop coordinated linkages to community agencies working closely with minority and ethnic groups.

The general lack of expertise in a number of important areas highlights the need for faculty training and continuing education for personnel in community mental health. If coordination of services, continuity of care, and effective use of interdisciplinary teams for service delivery and training is to become a reality, the social work profession needs to address the demand for workers and educators who have knowledge and skills in this area. The development and coordinated delivery of knowledge and skills for practice in community mental health is certainly a challenge that needs to be met.

This chapter has reviewed some recent developments in coordination, continuity of care, and the interdisciplinary team. It has emphasized the important role of the team for both coordinated practice and education in community mental health. Finally, it identified the need for continuing education for workers and educators in community mental health.

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II

Civil Rights of Mental Patients

BY LEILA CALHOUN DEASY

This paper addresses the issue of civil commitment to inpatient facilities of persons diagnosed as mentally ill.[1] Selected legal doctrines, judicial decisions, and state statutes that affect admission to, and discharge from mental hospitals are discussed,[2] as are the circumstances of institutionalized patients. In addition, the effect of recent developments in mental health law on relationships of lawyers and physicians is examined, and a role for social workers as mediators for patients is defined.

Background

There is emphasis in federal and state mental health legislation on the provision of treatment resources for patients of varying characteristics who suffer from a variety of illnesses of different degrees of severity. Much community mental health practice involves patients who seek treatment voluntarily, and who remain at home throughout the course of treatment. Others may choose brief or extended stays in halfway houses or in inpatient facilities. The issue of confidentiality with such patients presents a vexing problem, with the new emphasis on accountability to funding agencies—particularly since in most states the mental health worker's relationship is not seen as a privileged one under the law.

Nevertheless, the degree of control exercised by patients who seek treatment voluntarily is considerable. This is particularly true for those seen for limited periods of time each week, and at their own behest. It is also true for patients in day care, night care, or inpatient care in a community or even a long-term hospital, as long as their status is that of a voluntary patient. The person has the right to continue or terminate treatment, and their civil rights remain intact.

However, inpatients who are involuntarily hospitalized in psychiatric institutions are in a much more vulnerable position. Powerlessness has been the essential characteristic of patients who have found themselves in such a position. They have been powerless to determine whether they would be admitted in the first place, to influence the length of their hospitalization, or to make decisions about the nature and degree of therapeutic interventions. The lack of control that these patients exercise over their fate comes as a surprise to many social work students and others when they are first introduced to the psychiatric inpatient system.

There is a paradox here. For the most part, inpatients in psychiatric facilities have not been accused, much less convicted of any crime. Yet their rights to the most elementary freedoms—of movement, of access to home, family and friends, to raise their children, or to earn a living—have been abridged through the act of locking them up. Relatively few of these patients are forensic patients—that is, persons who have been implicated in some kind of illegal activity. But many of them are involuntarily hospitalized—committed against their will. Persons inured to such circumstances may not question them. Those new to the system, either as patients or as caregivers, may wonder how such circumstances have come about.

Justification for Involuntary Commitment Of Psychiatric Patients

Two justifications are advanced for the involuntary civil commitment of a patient to a mental hospital. The first is that even though the committed patient may not realize it, he or she may be expected to derive some benefit from hospitalization. This is the doctrine of *parens patriae*—that is, that the state acts as parent in the best interests of the patient, who is judged to be incompetent to decide or act on his or her own behalf. The second justification is that society may derive some benefit from the patient's involuntary hospitalization. The *police power* of the state is invoked in circumstances where the behavior of the patient leads to the inference that he or she may be or may become a danger to self or others.

Parens Patriae

Careful reflection on these two doctrines leads to sobering conclusions. For instance, invoking the doctrine of *parens patriae* or the principle that involuntary commitment will be beneficial to the patient, rests on some rather sweeping assumptions: (1) that the patients' present living circumstances are more deleterious to well-being than confinement in a (sometimes distant) mental hospital; (2) that inpatient care is needed, and that the care needed can be provided in the hospital to which the patient is being sent; and (3) that the patient will derive more benefit from hospitalization than might be provided by treatment in a less restrictive setting. In cases where the doctrine of *parens patriae* is invoked as justification for hospitalization, these assumptions merit careful examination.

To be removed from one's living circumstances means that one's opportunity to perform functions in a network of continuing role relationships must be set aside. One must learn behavior necessary for a new set of roles—as a member of a ward with other persons who live there because of their assumed psychiatric disabilities, and as a subordinate in a network of relationships with many strangers who exercise control: nursing attendants, psychiatric nurses, social workers, psychologists, psychiatrists, and all other personnel in a mental hospital. Goffman, Rosenhan, and others have written with feeling about the consequences of becoming one of a "batch" of people subject to the blandishments of the staff of a mental hospital.[3] Such an experience can have far-reaching consequences for the self-regarding attitudes of patients and for the attitudes of others toward them. Few would deny that there is some stigma attached to having been incarcerated in a mental hospital.

To be committed to a mental hospital for treatment means not only the loss of freedom and removal from familiar surroundings, it also means that one comes under the control of hospital staff who will decide on what modes of intervention will be used. These interventions might include talking therapies (individual and group), behavior modification, medication, electric shock, or psychosurgery (lobotomy). To monitor from the outside the treatment regimens of patients in the relatively closed system of the mental hospital is very difficult. Granted, the permission of relatives or other responsible persons may be requested prior to administering various types of therapies to patients not competent to decide for themselves. The fact that requests originate with members of the hospital staff whose judgment in such matters presumably is to be trusted means that such requests are likely to be granted.[4]

The third assumption, that the patient will derive more benefit from hospitalization than might be provided in a less restrictive setting, requires judgment based on the availability of alternatives to inpatient care.[5] It confronts the issue of deinstitutionalization as well. The need to develop suitable alternatives to inpatient care, particularly for patients who have been hospitalized for extensive period of time, is manifested in the developing literature on deinstitutionalization.[6]

Police Power

The second justification for involuntary hospitalization invokes the police power of the state, acting in the interest of restraining patients from doing harm to themselves or to others. Society's right and power to protect itself provides the basis for "dangerous person legislation, whether it governs sentencing practices, preventive detention, release from incarceration or *civil commitment*" [italics mine].[7] The power of the state to take away one's freedom most often is invoked in situations where persons are accused of, or have been convicted of crimes for which imprisonment has been determined to be an appropriate punishment. The use of preventive detention has not been commonplace in the American criminal justice system. Supreme Court Justice Jackson spoke to this issue.

> Imprisonment to protect society from predicted but unconsummated offenses is so unprecedented in this country and so fraught with danger of excesses and injustices that I am loathe to resort to it, even as a discretionary judicial technique to supplement conviction of such offenses as those of which defendant stands convicted.[8]

Involuntary hospitalization abrogates one's right to liberty, a right guaranteed to American citizens under the 14th amendment to the Constitution. Yet hospitalization in a mental hospital to protect society from predicted but unconsummated offenses against others, or dangerousness to others, is a legal basis for involuntary hospitalization in a majority of states.[9] It might be assumed that such a step, which has such potentially grave consequences for the person, would be taken under circumstances that have been carefully articulated. At issue are such matters as: (1) How is "dangerousness" defined? (2) How accurately can "dangerousness" be predicted? and (3) What procedural safeguards are provided to insure the rights of confined patients?

The statutes of the different states vary in the extent to which they attempt to define dangerousness. Some do not define it at all. Property damage or physical injury to others are sometimes used as criteria of dangerousness in certain state statutes that do define it.[10]

The burden placed on the examining physician is considerable. Note the decisions that must be made under Florida's Baker Act as justification for involuntary hospitalization: "he is mentally ill and because of his illness is: (a) likely to injure himself or others if allowed to remain at liberty or, (b) in need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf."[11] Yet Sturup stated that "little is known about assessing dangerousness beyond intuitive feelings,"[12] and Kozol asserted that "the terms used in standard psychiatric diagnosis are almost totally irrelevant to the determination of dangerousness" and that dangerousness "is not discernible through routine psychiatric examination."[13]

Given the difficulty of defining or diagnosing dangerousness, one would be led to question the ability of psychiatrists and others to predict whether a person would commit dangerous acts against himself or herself or others. A landmark case which addressed the issue is that of *Millard* v. *Harris:* "Predictions of dangerousness require determinations of several sorts: the type of conduct in which the individual may engage; the likelihood or probability that he will in fact engage in that conduct, and the effect such conduct if engaged in will have on others."[14]

Kozol, Boucher, and Garofalo questioned whether such predictions can in fact be made, and asserted:

> The difficulty involved in predicting dangerousness is immeasurably increased when the subject has never actually performed an assaultive act. This is particularly relevant to involuntary mental hospitalization and to proposals for preventive detention . . . No one can predict dangerous behavior in an individual with no history of dangerous acting out.[15]

And Stone also said:

> It can be stated flatly that on the basis of my own review of the published material on the prediction of dangerous acts that neither actuarial tables nor psychiatric intuition, diagnosis, and psychological testing can claim predictive success when dealing with the traditional population of mental hospitals.[16]

If dangerousness is difficult to define or to predict, its use as justification for involuntary civil commitment to a mental hospital forces one's attention to the circumstances under which such commitments take place. To what extent are procedural safeguards provided in order to protect the patients' rights? The traditional safeguards that have been provided to adults who are accused of crimes, and that have been extended to juveniles by the Gault decision, [17] traditionally have not been extended to psychiatric patients. However, in a recent case, Alberta Lessard, who had been apprehended by the police and taken to a mental health center because she allegedly was suicidal—a danger to herself—brought suit against the State of Wisconsin, alleging that:

> the Wisconsin procedure for involuntary civil commitment denied her due process of law in the following respects: in permitting involuntary detention for a possible maximum period of 145 days without benefit of hearing on the necessity of detention, in failing to make notice of all hearings mandatory; in failing to give adequate and timely notice where notice is given; in failing to provide for mandatory notice of right to trial by jury; in failing to give a right to counsel or appointment of counsel at a meaningful time; in failing to permit counsel to be present at psychiatric interviews; in failing to provide for exclusion of hearsay evidence and for the privilege against self-incrimination; in failing to provide access to an independent psychiatric examination by a physician of the allegedly mentally ill person's choice; in permitting commitment of a person without a determination that the person is in need of commitment beyond a reasonable doubt; and in failing to describe the standard of commitment so that persons may be able to ascertain the standard conduct under which they may be detained with reasonable certainty.[18]

The litany of errors of omission and commission listed above indicates the ways in which rights that would have been guaranteed to a person alleged to be guilty of a crime are said to have been abrogated with a person subjected to the civil proceeding of involuntary hospitalization in a mental hospital. This matter is of grave concern to members of the bar. Benton asserted that "incarceration (sic) of an unwilling individual for his own welfare ought to be possible only after a judicial hearing upon adequate notice. The sole issue at the hearing should be whether the individual is capable of deciding for or against hospitalization."[19]

Circumstances of Patients Committed to Mental Hospitals: Right to Treatment and Right to Freedom

Persons perceived as suffering from mental illness who are committed under the doctrine of *parens patriae* or of the police power of the state, become residents of mental hospitals. Since hospitals exist for the purpose of providing treatment, it should follow that a mental hospital is a setting in which patients receive treatment for mental illness. However, whether they do in fact receive treatment, what treatment is provided, and under what conditions, have been matters that have received intense scrutiny in recent years. An allied issue currently receiving attention is the right of involuntarily committed patients to refuse treatment.

Right to Treatment

Among court cases that have addressed the patients' right to treatment, three have received particular attention. The issue was addressed in *Rouse* v. *Cameron.*[20] Rouse was found not guilty, by reason of insanity, of carrying a dangerous weapon. Four years later he was still in a mental hospital. Had he been found guilty, the prison term would have been considerably less than four years. Judge David Bazelon upheld Rouse's right to treatment under the statutes of the District of Columbia by asserting that insufficiency of resources did not justify continued failure to provide treatment. However, the court's expectations of St. Elizabeth's Hospital, where Rouse was confined, were neither as specific nor as demanding as they might have been. To cite Stone:

> The court . . . did not articulate general judicial criteria for acceptable treatment. It did not demand cure, or even improvement or that the treatment used be the best possible. It asked only for a bona fide effort to provide an individualized treatment program with periodic evaluation.[21]

Rouse came to the attention of the authorities because of the alleged commission of a crime, so his commitment to the hospital was not a civil commitment. *Rouse* v. *Cameron* is often cited as a landmark case because of its implications for the "right to treatment" issue.[22]

However, Bazelon was addressing the rights of an individual, and so the implications were not so far-reaching as in the case of *Wyatt* v. *Stickney,* a class-action suit brought in Alabama. This is truly a landmark case in its assertion of the constitutional right to treatment of patients who are involuntarily confined to mental hospitals, and in its provision of criteria by which adequacy of treatment can be measured. The details of the case have been presented and discussed in an article that appeared in *Social Work.*[23] Prigmore and Davis described the actions taken by Stonewall B. Stickney, the Alabama Commissioner of Mental Health, in attempting to bring about a systems change in Alabama through emphasizing community care and prevention of institutionalization. His subsequent efforts to remain within his departmental budget through dismissing some of the professional employees at Bryce State Hospital in Tuscaloosa led to a class action suit that questioned the effect of this reduction in staff on the quality of patient care. The suit was dismissed by Judge Frank Johnson because no constitutional issue was raised. However, when a suit subsequently was filed on behalf of patients, constitutional issues were addressed by Judge Johnson. According to Prigmore and Davis, "the central constitutional position established in Wyatt v. Stickney is that involuntary commitment requires the granting of a wide range of rights to residents of public hospitals and institutions."[24] It was established by the court that:

> There can be no legal (or moral) justification for the State of Alabama failing to afford treatment and adequate treatment to several thousand patients who have been cruelly committed . . . for treatment purposes. To deprive any citizen of his or her liberty upon the theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.[25]

Defendants in the case were ordered to prepare and file a report that would address specific issues raised by the court. When that report was filed, the court ruled that the proposed treatment program "was deficient in three fundamental areas. It failed to provide (1) a humane psychological and physical environment; (2) qualified staff in numbers sufficient to provide adequate treatment; and (3) individualized treatment plans."[26] It was concluded that minimal medical and constitutional standards were not being met. A formal hearing was ordered in which "the parties and *amice* would have the opportunity to submit proposed standards for constitutionally adequate treatment and to present expert testimony in support of their proposals."[27]

There followed the specification of:

> detailed standards of treatment entered in an appendix to the decision under force of law which address a number of fundamental issues. Among rights defined are the rights: to privacy and dignity, to least restrictive conditions, to send sealed mail, to telephone communication and to have visitors, to have clean clothes, preferably their own, to outdoor physical exercise, to attend worship services. They also are guaranteed the right of freedom from . . . physical restraint and isolation: . . . from unnecessary or excessive medication . . . not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give consent, and of his guardian or next of kin, after consultation with independent specialists and with legal counsel.[28]

Standards set forth in Wyatt are seen by Stone to be similar to regulations set by HEW that must be met by psychiatric institutions in order for them to qualify for medicaid and other federal compensation.[29] Wyatt stands as the most comprehensive right to treatment case, having been upheld on appeal.[30]

Right to Freedom

The Wyatt case did not reach the Supreme Court, but when the *O'Connor* v. *Donaldson* case was argued before the Supreme Court in January 1975, the justices' decision was awaited with much interest. It was thought that the constitutional issue of right to treatment might be decided once and for all. Such, however, was not to be the case.[31]

Kenneth Donaldson was hospitalized at the Florida State Hospital in Chattahoochee in January 1957. He remained there for 15 years, despite numerous attempts on his part and on the part of others to secure his release. Donaldson's account of his life in Chattahoochee, chronicled in his *Insanity Inside Out,* provides chilling details about the everyday lives of involuntarily committed mental patients.[32] It is reminiscent of other descriptions such as Rosenhan's "On Being Sane in Insane Places,"[33] and provides ample evidence of the need for concern about the welfare of patients in mental hospitals.

Donaldson based demands for his release on the assertion that he was not mentally ill, not dangerous, and that while hospitalized, he was not being treated for his supposed illness. A Christian Scientist, Donaldson had refused to take electric shock or medication. However, other forms of treatment such as grounds privileges, occupational therapy, and conferences with the ward physicians had been denied him. Donaldson reported that the ward physician responsible for his care for an eight-and-a-half year period spent no more than two hours with him during the entire period—"an average of about fourteen minutes a year."[34]

"The evidence showed that Donaldson's confinement was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness. Numerous witnesses . . . testified that Donaldson had received nothing but custodial care while at the hospital."[35] Even though the Fifth Circuit Court of Appeals decision in the Donaldson case had affirmed a constitutional right to "such treatment as will give (the patient) a realistic opportunity to be cured or to improve his mental condition,"[36] the Supreme Court did not affirm a constitutional right to treatment. Instead, it addressed the issue of the constitutional right to freedom. The decision of the court was that

> "a state cannot constitutionally confine without more (sic) a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." Since the jury found, upon ample evidence, that O'Connor, as an agent of the State, knowingly did so confine Donaldson, it properly concluded that O'Connor violated Donaldson's constitutional right to freedom."[37]

Role Relationships of Lawyers, Judges, and Physicians

The Rouse, Wyatt, and Donaldson decisions made powerful inroads into the authority exercised by psychiatrists over the lives of involuntarily committed mental patients. They are but three of many cases in which attorneys, judges, and psychiatrists have met in the courtroom in classic confrontations of the psychiatric and legal professions. On the lawyers' home ground, what have been defined by psychiatrists as medical problems are translated into legal problems. To quote Dershowitz:

> civil commitment of the mentally ill is a legal problem; whenever compulsion is used or freedom denied—whether by the State, the church, the union, the university, or the psychiatrist—the issue becomes a legal one; and lawyers must be quick to immerse themselves in it.[38]

In the courtroom setting, results of differences in the socialization process of the two professions become apparent. Consultation with a view toward arriving at consensus is characteristic of psychiatric practice. Emphasis on differences, with the expectation that one of the op-posing viewpoints will prevail, is characteristic of legal practice. The psychiatrist has not been schooled in the adversary process, as has the attorney. Psychiatrists' performances in his court led David Bazelon, Judge of the United States Court of Appeals, District of Columbia Court, who played a major role in *Rouse* v. *Cameron*, to state that "in no case is it more difficult to elicit productive and reliable expert testimony than in cases that call on the knowledge and practice of psychiatry."[39]

Bazelon argued for the importance of monitoring professional performance, particularly of psychiatrists, through use of the adversary process, "because decisions granted on this discipline and on counsel from its practitioners are employed by the state to confine people against their will and to treat people in ways they do not ask for."[40]

What is the fate of the patient in all of this? Is there any danger that his or her needs will go unmet? Robitscher calls our attention to problems currently being confronted by psychiatrists:

> The legalistic approach takes the psychiatrist out of the driver's seat, important decisions concerning the conduct of mental hospitals are made not by psychiatrists and legislatures but by judges and civil rights lawyers who see it as their mission to change the mental hospital and have the legal power to do so but do not have the responsibility for patient care.[41]

Social Workers as Mediators for Patients

Laws change and court decisions are handed down. The fact of the matter is that there continue to be persons in need of hospital care for their mental disturbances. While the lawyer is concerned with the patients' legal problems and the psychiatrist is concerned with the patients' medical problems, someone must be concerned with the patients' *person* problems. This is a legitimate role for the social worker.

In today's mental health practice field, it is incumbent upon the social worker to become knowledgeable about legal issues affecting mental hospital treatment, as it always has been incumbent upon the social worker to be knowledgeable about medical treatment. The responsibility of schools of social work in enabling students to build a knowledge base in preparation for such practice should be clear to social work educators. For perhaps more so than previously, the advocacy role for the social worker in mental health is in need of clarification and emphasis. There is danger of indiscriminate release of patients to an uncertain future in an unsupportive community. The worker, in assisting patients to assess their treatment needs and the resources available to meet those needs, may help them make wise use of newly available freedoms.

NOTES

1. I am grateful to my colleague Carolyn I. Steele for her helpful criticisms of an earlier draft of this paper.

2. The writer has attempted to choose from voluminous materials available on these matters, those which are most salient. For readers who wish to read further, the following works may be consulted: Alexander D. Brooks, *Law, Psychiatry and the Mental Health System* (Boston: Little, Brown and Company, 1974), especially Chapters 8 through 16 and the Appendix; Alan A. Stone, *Mental Health and Law: A System in Transition* (Washington, D. C.: U. S. Government Printing Office, 1975), Chapters 1, 2, 4, 5, and 6; and Donald Brieland and John Lemmon, *Social Work and the Law* (St. Pa[illegible]nn.: West Publishing Co., 1977), Chapter 23.

3. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N. Y.: Doubleday and Co., 1961); and D.L. Rosenhan, "On Being Sane in Insane Places," *Science*, Vol. 179 (1973), pp. 250-58, reproduced in Brooks, *op. cit.*, pp. 826-42.

4. Brooks, *op. cit.*, Chapter 15, "The Right to Refuse Treatment," pp. 877-924.

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14. *Millard* v. *Harris*, 406 F.2d 964 (D. C. Cir. 1968). Contained in Brooks, *op. cit.*, p. 569.

15. Kozol et al., *op. cit.*, p. 392.

16. Stone, *op. cit.*, p. 33.

17. *In re* Gault, 387 U. S. 1, 70, 87 S.Ct. 1428, 1466, 18 L. Ed., 2d 527 (1967). Quoted in Brooks, *op. cit.*, p. 626.

18. *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E. D. Wis. 1972). Quoted in Brooks, *ibid.*, p. 621.

19. Robert T. Benton, "Criteria in Civil Commitment Procedings," *University of Miami Law Review*, Vol. 26 (Summer 1972), p. 691.

20. *Rouse* v. *Cameron*, United States Court of Appeals, District of Columbia Circuit, 1966, 125 U. S. App. D. C. 366, 373 F.2d 451. Quoted in Brieland and Lemmon, *op. cit.*, pp. 739-47.

21. Stone, *op. cit.*, p. 85

22. *Rouse* v. *Cameron* does illuminate the plight of forensic patients who have been confined to mental hospitals long after the time they would have completed the maximum sentence they could have been given had they been convicted and sentenced. The "insanity plea" may bring worse consequences than are anticipated.

23. Charles S. Prigmore and Paul R. Davis, "Wyatt vs. Stickney: Rights of the Committed," *Social Work*, Vol. 18 (July 1973), pp. 10-18.

24. *Ibid.*, p. 18.

25. *Wyatt* v. *Stickney*, United States District Court, Middle District of Alabama, 1972, 344 F. Supp 373. Quoted in Brieland and Lemmon, *op. cit.*, p. 749.

26. Prigmore and Davis, *op. cit.*, p. 13.

27. Brieland and Lemmon, *op. cit.*, p. 748.

28. *Ibid.*, pp. 750-51.

29. Stone, *op. cit.*, p. 88.

30. Brieland and Lemmon, *op. cit.*, p. 752.

31. *O'Connor* v. *Donaldson*, Supreme Court of the United States, 1975, 422 U. S. 563, 95 S. Ct. 2486, 45 L. Ed., 2d 296. Quoted in Brieland and Lemmon, *op. cit.*, p. 753.

32. Kenneth Donaldson, *Insanity Inside Out* (New York: Crown Publishers, 1976).

33. Rosenhan, *op. cit.*

34. Brooks, *op. cit.*, p. 1,128.

35. Supreme Court of the United States No. 74-8, *J. B. O'Connor Petitioner* v. *Kenneth Donaldson* (June 26, 1975), reprinted in *Memo from the Director*, National Institute of Mental Health, 1975, p. 23.

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37. *Ibid.*, p. 30.

38. Alan M. Dershowitz, "The Psychiatrist's Power in Civil Commitment: A Knife That Cuts Both Ways," *Psychology Today*, Vol. 2 (February 1969), p. 47.

39. David L. Bazelon, "Psychiatrists and the Adversary Process," *Scientific American*, Vol. 230 (June 1974), p. 18.

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41. Jonas Robitscher, "Evolving Commitment Practices—The Past Quarter Century" (Remarks delivered at the APA Institute on Hospitals and Community Psychiatry, Miami, Florida, September 18, 1973), p. 3.

III

Clinical Social Work in Community Mental Health Programs

BY PATRICIA L. EWALT

Clinical social work in community mental health programs derives its mandate from community mental health objectives as well as from the objectives of the social work profession. Community mental health objectives are, however, extremely ambitious and vague. All might agree that they include provision for comprehensive, accessible, high quality care to all segments of a defined population. Yet each element of this definition is open to interpretation. What, in fact, is included in the definition of "care?" Are we to be concerned with people who do not have identified problems as well as those who do? With people whose problems are unlikely to improve as well as those whose progress is easier to demonstrate? How varied do services have to be in order to be of high quality and truly accessible to all? When goals are both vague and more ambitious than resources allow, choices eventually must be made. Although social work often has been associated with the "mental health professions," social work's answer to the question, "What is it important to do?" may not be the same as that of other professions.

The purpose of this chapter is to define some current issues for clinical social work in mental health programs. First, investment in programs for people who do not have identified psychosocial problems—so-called preventive programs—will be considered. Second, the need for allocation to programs for both immediate, brief intervention and for long-term care will be presented. Third, variations in service delivery taking into account ethnic, racial, and class differences will be discussed. Finally, implications for social work education will be suggested.

Social work is not merely a guest in the house of community mental health. Resource allocation in community mental health programs and the role of clinical social workers in these programs should be determined, to a considerable extent, by the workers themselves. Conceptualization of the objectives shared by all social workers, and by clinical social work in particular, should provide guidelines for decision making. That there is no universal definition of these objectives only makes the task more difficult. The overriding issue for clinical social workers in community mental health programs, therefore, may be a definition of their mission.

A Definition of Clinical Social Work

A definition of clinical social work will be offered here since a determination of clinical social work's intent is basic to all further decision making. This definition will serve as the framework for the ensuing discussion. The definition is as follows: as with all social work, the purpose of clinical social work is to improve the quality of life[1] by enhancing or maintaining interactions between people and the environment.[2] Fulfillment of this purpose requires a dual focus on enhancement and restoration of the social functioning of people, and enhancement and restoration of the ability and will of social institutions to respond to and respect people.[3] This purpose pertains to all persons, but carries a special responsibility to those who are disadvantaged owing to race, sex, age, economic class, or disability.

Within this overall social work framework, the initial focus of clinical social work is on individuals and families. Nevertheless, since the goal of social work is enhancing or maintaining *interaction* of persons with their environment, environmental factors are as important in assessment as individual and family factors. Most importantly, in the service of enhancing interaction, the interventions that flow from the assessment may address the environment, the family, the individual, or all three. The distinguishing characteristics of a social work clinician, as contrasted with other disciplines, are the obligation and the knowledge-based skill to address environmental factors if they require enhancement or change. Addressing the environment includes the marshalling of interpersonal or institutional resources, either by facilitating the client's doing so, or by advocacy, mediation, or other professionally disciplined activities on the client's behalf.

This definition does not rule out a focus primarily on personal counseling when needed. It is sometimes suggested that when social workers provide personal counseling they do not sufficiently differentiate themselves from other disciplines. However, the difference lies in the explicit focus on interaction, and especially in the obligation to choose personal counseling only when it is judged more suitable and necessary than environmental intervention.

Clinical social workers have a responsibility that extends beyond the needs of their clients. As services are performed, inadequacies in social resources are identified that pertain to clients and nonclients alike. It is incumbent on clinical workers to identify these inadequacies and seek means by which they may be addressed.

The hallmark of a clinical social worker as contrasted with other clinicians is, therefore, acceptance of the obligation to assess the environment and the person, and to address either aspect as needed. These ideas are the basis for the ensuing discussion. At least they may stimulate a more adequate conceptualization than now exists. It is difficult for clinical social workers to influence community mental health programs in a systematic way without an adequate definition of their shared objectives.

Prevention

One of the most difficult issues for clinical social work in mental health programs is the proper allocation of resources between remedial services for those who already have emotional difficulties, and so-called preventive services for those who do not. The issue is very difficult to define, let alone to resolve. First of all, what is prevention? Kessler and Albee concluded:

> practically every effort aimed at child-rearing, increasing effective communication, building inner control and self-esteem, reducing stress and pollution and the like— in short, everything aimed at improving the human condition, at making life more meaningful—may be considered to be part of primary prevention of mental or emotional disturbance.[4]

Caplan and Grunebaum asserted that primary prevention consists of ensuring to people the optimal provision of physical, psychosocial, and sociocultural resources.[5]

At first these definitions sound very comforting to a social worker. The goal seems to be improvement of the quality of life, which also is the goal of social work. But what does that have to do with the primary prevention of mental or emotional disturbance?

Everything and nothing. There are countless studies that indicate correlations between undesirable living conditions and mental disorders, but no definitive causal links. The critical variables, if they exist, are unknown.

Early in the life of the community mental health centers program, it was argued that "although we currently have little definite knowledge of the specific factors which are etiologic in specific mental diseases, there exists a body of plausible assumptions about factors which may be significant in primary prevention."[6] Even though this statement was made by a strong proponent of primary prevention, note the use of "little definite knowledge" and "plausible assumptions." Yet the idea that mental illness could be prevented—even though it is a very old and unsuccessfully implemented idea[7]—was advocated as a service rather than a research component of mental health centers.

It may be instructive to review the developmental shifts, or as some would see it, the goal displacement, in the concept of prevention as community mental health programs developed. In 1961, a report entitled *Action for Mental Health* advocated prevention through research into the causes of mental illness.[8] Consultation and education were emphasized as worthwhile but not as related to prevention. In 1963 President Kennedy mentioned prevention as an activity of centers but particularly advocated it in the form of research and health, education, and social welfare programs *outside* the mental health purview.[9] It was as the regulations of the Community Mental Health Centers Act were implemented that prevention came to be conceptualized as a *service* component *within* centers. Psychological and social programs were advocated, not as research into what might work, but as programs that were assumed to work.

Three noteworthy shifts had taken place. First, at least some of the onus for painstaking analysis of effectiveness was removed. Second, there was an implication that mental health programs had an overriding responsibility and expertise to deal with quality of life, a kind of "corner on the market."[10] There was an ominousness to this kind of promise, presumptuous given the state of knowledge, and harmful in seeming to relieve others of a share of responsibility for the well-being of people. Finally, consultation, education, and related activities, instead of being favored as worthwhile in their own right, were justified as prevention. Some even advocated the diversion of all professional personnel into such activities because they could be expected to prevent mental illness.

The crop that was sown with these ideas is now being reaped. After fifteen years of investment in preventive activities, there is no

41

evidence whatsoever of the prevention of mental disorder by means of social interventions. Klein and Goldston, advocates of primary prevention, prescribed the following conditions for demonstrating its achievement:

> An activity deserving to be described as prevention should generally include the following elements:
>
> 1. A condition which can be observed and recorded in precise terms.
> 2. An identified population at risk for that condition.
> 3. A measure of the incidence of that condition in the population.
> 4. A clearly defined plan for intervention applied to the identified population.
> 5. The measurement of incidence following the interventions.[11]

No mental health interventions have met these criteria. It seems ironic that in two recent reports of national conferences to promote primary prevention, *Primary Prevention of Psychopathology* and *Primary Prevention: An Idea Whose Time Has Come,* not one program demonstrated prevention of mental illness. Most did not even have an evaluative design.[12]

These findings—or lack of them—seem extremely pessimistic and may seem to dictate a withdrawal from all activities except direct care of clients with emotional problems. That is not necessarily so, but a change in strategy and rationale certainly seems indicated.

Some psychiatrists have said that since prevention has not been effective, they have an obligation to return to patient care, to devote themselves to the major activity for which they were trained.[13] The answer for social work is not the same. We are trained—and more importantly, it is our objective—to improve the quality of interaction among people, and between people and their environment, regardless of whether they have identified emotional problems, and especially regardless of whether our services prevent mental illness. It is essential to rid ourselves of the primarily medical rationale of "prevention" for these activities. We engage in services to promote quality of life. For better or worse, social work does not proceed altogether on the basis of normal science, posing refutable hypotheses that can be rejected.[14] The value of realization of the fullest possible potential of each individual is not a refutable hypothesis. If some feel that this is a very unscientific approach, at least it is more honest than a pseudoscientific claim of prevention.

It also points the way to the kind of empirical evidence that would be helpful: do people seem to feel and function better as a result of interventions, regardless of the issue of mental illness? Some programs called "primary preventive" have, in fact, been able to demonstrate this kind of result.[15] The pursuit of research to understand causal links between environment and mental illness also should be continued, but it should be regarded only as research and not as a service program assumed to be fully effective.

Hence our overall mission as social workers justifies, indeed requires, programs for which we identify a need in the course of clinical work, but which are not necessarily devoted to people with mental problems. If it is discovered, for example, that a new mother is lonely, isolated, and unduly blaming herself for difficulties with her infant, it does not require a prevention rationale to organize a peer-support group that would make resources available to help overcome the problem.

A social worker and student organized such a program as part of a child abuse prevention unit, though it will never be known whether any abuse was prevented. Nevertheless, the program is a resource for new mothers whether or not they have emotional problems. Another student, noticing her client's anxiety about radiological treatments, urged the hospital to provide an orientation for all patients about to undergo such treatment. This may not prevent breakdown, but it could be helpful. An experienced worker made herself available for police calls when officers anticipated interpersonal problems, regardless of whether they occurred among identified clients.

Why should social workers in mental health centers undertake such activities when a mental problem is not necessarily involved? Because comprehensiveness is a part of the mental health idea, ranging from the most longstanding and serious mental problems, to stresses in daily living not identified as mental problems. Mental health centers cannot (and should not) imply that they can address all these stresses. But since centers exist as a major component of the helping services, and especially since social workers exist within them, centers are responsible for addressing at least some portion of the human stress situations they encounter. Needs that cannot be met at least can be documented systematically and revealed. A shortage of money is often mentioned as a reason for lack of investment in the indirect services: "lack of money" really means lack of public commitment—a commitment that cannot be engaged without the commitment and leadership of the profession.

Brief and Extended Intervention

Since consultation and education programs cannot be expected to prevent emotional problems, there is a continuing need for service to people who already have these problems. Social work, the largest professional group in community-based mental health systems in this country, bears a large share of responsibility for such services.

In accordance with the definition offered at the outset, these services may include either personal counseling or the marshalling of interpersonal and institutional resources as needed. The author has already taken the position that there should be some allocation of resources to people who do not have identified problems. Among those who do, there also are issues of equitable allocation. Two will be addressed: the need for planned short-term intervention for acute upsets, and the need for planned long-term care for chronic, largely irremediable conditions. Purposeful planning of both brief intervention and long-term care has been somewhat neglected.

Planned Short-Term Intervention

Community mental health policy has emphasized emergency and short-term interventions, which often are justified on the basis that they will prevent more serious illness. Like other claims of prevention, however, there is no evidence that this is so. However much we may believe in the value of crisis intervention, for example, there is no evidence that more serious mental problems would occur without it or are prevented by it.[16] As with the promise of prevention by other means, it is unwise and unnecessary to make professional promises that cannot be kept. The social work rationale for availability of immediate intervention is that if services are available to some in private care, they should be available to all under public auspices.

Brevity of intervention has been justified on the basis of making at least a little care available to a lot of people since availability to all is both a social work and a mental health mandate. Many workers resist this rationale, feeling that it is based on fiscal constraint rather than clinical indicators. There is, however, substantial evidence that *planned* brief treatment may best meet clinical needs as most clients themselves define them.

Since personal counseling became a professionally disciplined service early in this century, the duration of service used by the majority of people has always been brief. This is not a recent phenomenon and is true regardless of auspices in public or voluntary agencies or in private practice. Despite professional preference for long-term care and emphasis on training to provide it, clients in family service agencies, VA outpatient clinics, child guidance clinics, and private offices have an average length of stay of about only five to seven visits. A large proportion of persons use only one visit.[17] Neither cost to the client nor social class appear to alter this preference for brief contact.

For example, under the Federal Employees Health Benefit Plan, which primarily insures white-collar workers, 80 percent of the approximately sixty thousand persons who used outpatient psychiatric care during 1971-1973 used a mean of about seven visits.[18] This occurred despite the fact that after a $100 deductible, an unlimited number of outpatient psychiatric visits was permitted, with 80 percent of the costs reimbursed. Insurance programs primarily for blue-collar workers, whether utilized in mental health centers, prepaid group practices, or private offices, showed similar average durations of stay.[19]

As Parad so aptly stated, the question is not whether brief treatment will occur, since most clients in fact use only a few visits, but whether it will occur in a planned manner or by default.[20] Social policy emphasis on brief treatment, and fiscal constraints which force this policy into effect, probably do neglect the needs of some individuals for longer, more intensive care. Nevertheless, insofar as they cause workers to make explicit plans, mutually agreed upon with clients, to achieve limited goals in a short and specified period of time—the essentials of *planned* short-term intervention—they may bring about planning better suited to the actual care-seeking patterns of the vast majority of people.

Lengthy treatment plans to provide what workers believe clients really need, may help workers feel they are discharging their professional responsibility. Blame then tends to fall on clients who "drop out" of the well-laid plans. In fact, professional responsibility may be discharged better by recognizing the fact that most clients will stay only a short time and then planning accordingly. Paradoxically, one of the few ways that has been found to extend the number of outpatient visits beyond the expected mean of five to seven is a planned period of contact of about ten visits.[21] People are more likely to participate than if the time element is left open-ended, and it is always possible to recontract for a further period if that seems necessary to clients and workers.

Planned Long-Term Care

The previous discussion focused on brief versus long-term intensive intervention. Most people do not appear to want lengthy, in-depth attention. However, just because they desire only limited attention to their problem does not mean that all long-term planning is unnecessary. The community mental health emphasis on immediate, brief intervention for people with acute problems has tended to neglect the vast number of persons with chronic disabilities. It may be noted that in the regulations for the original Community Mental Health Centers Act, the five prescribed services focused either on acute care (inpatient, outpatient/emergency, and partial hospitalization) or on the general population (consultation and education).

Aftercare and rehabilitation were regarded as optional.

Lack of transitional residences and other supportive services for formerly institutionalized persons is now widely recognized as a shortcoming in a truly comprehensive mental health program. However, even a focus on the need for *transitional* care fails to recognize the *permanent* need for supportive services by many people. Morris estimated that approximately 10 percent of the U.S. population had irremediable impairments that caused them to be partially or totally dependent.[22] Owing to changes in health care, this proportion is increasing. Many retarded and multiple handicapped persons who formerly would have died in infancy are now surviving. Retarded and schizophrenic individuals who formerly would have been institutionalized are now more likely to remain in the community and bear children, a high proportion of whom can be expected to have similar problems. As people live longer, the proportion of persons affected by senility increases. In addition to those with mental disabilities, the proportion of persons with genetic or acquired physical handicaps also is increasing. Not only the individuals directly affected, but also their families may require supportive or respite services. An increasing number are likely to come to the attention of social workers in mental health facilities, since institutional facilities often are unavailable or considered undesirable, and the stress of providing long-term care at home is considerable.

As Morris pointed out, the objective of service for the chronically handicapped must be care, not cure. Although they may have acute upsets and immediate needs, their long-term needs are not adequately addressed by brief intervention. Both with chronically handicapped persons and with their families, there is likely to be a need for periodic and diverse services within a long-term plan.

Use of planned brief intervention techniques is not necessarily contrary to the needs of those with a chronic disability. Specificity in dealing with social and emotional needs at any particular time is desirable. An attitude is required that dealing with needs repeatedly over an extended period is to be expected, and does not represent failure of the client or the worker, since "cure" is impossible. Reference to the "revolving door" phenomenon—as if people should be cured once and for all—does not take into account long-term disability or even periodic needs of people who usually can function on their own.

Adapting Care to Suit Ethnic, Racial, And Class Differences

Community Mental Health programs are charged with developing purposeful variations to meet the needs of a pluralistic society. The mode of service delivery, the personnel, and the site should take into account the cultural groups to be served. Many feel it is insufficient to develop programs that suit a vaguely defined "community" of one or two hundred thousand people, since such models are likely to reflect the needs of the dominant white majority. For example, since kinship and workplace relationships are particularly important in certain working class ethnic groups, it has been suggested that services based in the neighborhood or workplace[23] and family-focused intervention[24] are particularly important. The need for professional persons of similar background is strongly emphasized.

Care must be taken in trying to address the needs of all subgroups in society, that the perceived needs are not stereotyped and therefore racist. For example, with respect to appointment times it has been asserted that lower-class persons may not regard clock time as important as middle-class persons. Rigid adherence to appointment times therefore would be unreasonable. Greenlick et al. found that lower-class persons kept health care appointments less frequently during regular hours than others, and more frequently came in after hours and on weekends without appointments.[25] However, Goodrich et al. found that when specific appointments were given, lower-class persons used more health care than formerly.[26] An assumption that all lower-class persons prefer not to have appointments obviously would be in error.

People's preferences regarding the site of care also varies. A neighborhood location often has been advocated for low-income and minority groups. Use of children's mental health services by a predominantly Black and Spanish-speaking population in New Haven, Connecticut, increased from virtually none to 7 percent of a health care group population when a neighborhood health center was made available.[27] A low-income population in St. Louis preferred the use of outreach mental health centers over the use of the main hospital.[28] However, clients sometimes indicate that they prefer the anonymity of service received outside their own neighborhoods. It seems extremely important, therefore, to be sensitive to ethnic, racial, and class preference, yet to allow for the variations in service delivery within any one racial or cultural group that would be allowed across all groups.

The necessity for a range of options also pertains to types of service and personnel needed. It sometimes has been asserted that poor persons and minorities suffer so much structural disadvantage that social intervention should be focused on the environment rather than on individuals. Personal counseling is said to be a form of blaming individuals for problems that belong to their environment. At best, such efforts are said to be useless without environmental change. While environmental modification is surely desirable, poor and minority persons do not necessarily share the opinion that counseling is unnecessary. Gottesfeld found that Black professional and nonprofessional staff of mental health facilities felt more frequently than whites that traditional mental health services were important.[29] McCoy et al. found that low-income clients, without variation by race, "gave their strongest endorsements to activities traditionally associated with mental health programs." Less than half felt that the mental health program should emphasize improving neighborhood quality of life and almost one-fourth thought the program should not become involved in such activities at all.[30]

Past studies that have indicated less use of counseling services by minority and lower-income persons may have had more to do with the service delivery structure than with the characteristics of clients. Weiss, Freeborn, and Lamb found that within a prepaid group practice plan, where total health care was provided within one organization and the fee was not a factor, low-income persons used more mental health care than the general health plan membership.[31] In a similar setting, Ewalt found no difference in rate or extent of mental health care use by minority and nonminority members.[32] Cohen and Hunter found that when insured care was provided to union members in a mental health center, and special effort was made to interpret the nature of the services, a higher rate of utilization was reported by blue-collar workers and families enrolled in that plan than by any other prepaid or insured group throughout the country.[33] Therefore, professional conviction that environmental change is preferable to counseling, or the bias that low-income or working-class clients do not use mental health service, should not be allowed to diminish direct service to those populations.

Especially during the 1960s, similarity in background of helper and client was urged as desirable when serving low-income people.[34] Similar pairing sometimes has been urged for ethnic minority clients and workers. However, this can obscure a number of pitfalls. Assigning low-income, indigenous nonprofessionals to low-income clients, which was once highly advocated as providing better service—at least in certain ways for certain clients—is now viewed by some as discriminatory and racist. As with so many service modifications for disadvantaged people, although the intent is said to be "different and better," the result may be "separate and unequal." Aides have been found to perform a useful function in enhancing the use of health services of various kinds.[35] But vigilance is needed to be sure that nonprofessionals are not assigned owing to neglect or to an erroneous assumption that low-income persons do not want or need professional care.

Many clients would prefer to have a worker of their own race or ethnic group. Such a preference is not, however, overwhelming. The competence of the worker appears to be a more important factor to most clients than race.[36] It is necessary to take into account the possibility that minority members would in fact prefer workers of a common background but have not been able to rid themselves of the historically imposed stereotype that white skin equals greater competence. Nevertheless, there are drawbacks to pairing minority clients and workers. Responsibility for minority issues might be relegated to minority professional people only. This is undesirable, particularly since there are too few minority workers to provide service for all minority members even if it were desirable.

Care to avoid or correct problems within the interventive relationship is just as important when the pair is similar as when they are different. Similarity of worker and client is not always desirable. Workers who come from disadvantaged backgrounds (just as workers who do not) may expect too much from their clients, since they themselves have achieved a great deal, or too little because they pay less attention to clients' abilities than to the suffering they have experienced. Therefore, it seems important that *all* workers take responsibility for effective work and advocacy for minority clients; that minority workers be available, if possible, for minority clients who prefer similarity; and that nonminority as well as minority workers assess accurately without stereotyping, the needs and goals of each client.

Implications for Social Work Education

Educational preparation for clinical social work in community mental health programs is indeed extensive. Rationales have been presented for social work intervention with people who do not have an identified mental health problem and with those who have short-term and long-term needs related to a specific problem. Knowledge-based skills related to all these areas are required if social work service is to be distributed and effective in an equitable manner. Understanding specific influences and needs related to cross-cultural matters is essential. Substantive knowledge regarding the problem to be addressed, mental disorders in their various manifestations, also is indicated. The necessary extent of such knowledge requires definition by the profession.

To an extent, the knowledge required for clinical mental health work is shared not only by other clinical social workers but by all social workers. Areas of needed emphasis—for example, long-term care of the permanently handicapped—have been relatively neglected by policy, research, and human behavior components as well as by clinical practice.

When educational needs for a field of practice become exceedingly diverse, the burden of agencies to provide needed knowledge may become disproportionate to that of the schools. In turn, agencies constrained by many influences other than social work may emphasize only a portion of the practice knowledge and skills that the profession deems essential to fulfill its mission. It seems necessary for social work —with faculties and practitioners working together—to define its own view of the mission of community mental health programs and of the clinical social workers within them.

NOTES

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5. Gerald Caplan and Henry Grunebaum, "Perspectives on Primary Prevention," in *Critical Issues in Community Mental Health*, ed. Harry Gottesfeld (New York: Behavioral Publications, 1973).

6. *Ibid.*, p. 127.

7. Nathan Allen in 1878 advocated "the dissemination of more correct views of the true way of living to diminish the frequency of insanity." "The Prevention of Disease and Insanity," in *Proceedings of the Fifth Annual Conference of Charities* (Boston: F. Williams, 1878), p. 86. For a discussion of the effectiveness of mental health education and social change efforts in relation to mental illness, see Elaine Cumming, "Primary Prevention—More Cost than Benefit," and Lawrence C. Kolb, "Against the Radical Position in Community Mental Health," in Gottesfeld, *op. cit.*

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IV

Standards and Uses for Program Evaluations

BY HARRIS K. GOLDSTEIN AND JAMES PROCTOR

This paper offers standards for evaluating the work of a mental health evaluator, and the uses to which these evaluations may be put. Both administrators and service providers may use these standards to judge the evaluator's work; the evaluations may be used by mental health administrators, program managers, supervisors, and service providers.

This focus on evaluating the output of the evaluator rather than on "evaluative research" is deliberate. In community mental health centers the evaluator is expected to carry out many activities other than the study of the effect of programs or the comparison of outcomes from two or more programs. These activities use "accountability" in the broadest sense, and range from providing assurances that services are based on need, to determining if the quality of service meets agreed on standards.[1]

In taking this focus, this chapter attempts to contribute something different from that otherwise found in the literature on evaluation. Bernstein and Freeman have provided "information on the scope of the evaluation research endeavor, on the organization and people who do the work and on the methods employed."[2] There are several good methodological texts on "evaluation research," such as those by Suchman, Caro, and Rossi and

Williams.[3] Studying program effectiveness requires the same kind of design as studies of effect, but one further step must be taken—that is, one must compare the effects with those desired, or one must look at the extent to which objectives must be met. Effectiveness is thus a value judgment made after the data from evaluative research is in.

Research has shown that administrators expect about 90 percent of their evaluators' time to be spent in activities other than studies of effect. Evaluators are asked to conduct studies of needs, to evaluate the influence of individual and group treatment given by service providers, and to carry out cost-effect studies showing either the costs of reaching various kinds of outcomes, or the relative costs of various programs or treatments. The development and maintenance of management information systems increasingly are being expected of the evaluator. These show characteristics of patients who come into the program; of staff who treat them; the kind, intensity, and frequency of various activities of service providers; and how these relate to what happens to clients, such as rehospitalization, return to the community, and so on. Experience has shown that the evaluator is the person who is asked to complete the many reports required to show agency compliance with federal and state standards. The extent to which agency resources are utilized, and an analysis of whether the quality of service meets expectations (quality control) all come under the auspices of the evaluator.

Added to these are the difficult tasks of measuring such activities as the continuity of care provided and the effect of consultation and education activities. Because evaluators are closest to and have access to facts and data, they frequently are asked to participate in or manage public relations. And last but not least, evaluators often are expected to participate in grant writing, at least in helping to state the objectives in measurable and operational form, and in writing the evaluation section of the grant. In some cases, they are asked to write complete grants.

All of this indicates that the evaluator in a mental health agency is a generalist rather than a specialist. A study done by one of the authors shows the following expectations of administrators on how evaluators should spend their time:

1. Program monitoring and feeding back findings to improve programs —19 percent.
2. Management information systems, including patient or client characteristics, staff time spent in various activities and what happens to patients or clients—16 percent.
3. Showing agency compliance with federal or state standards and resource utilization—15 percent.

4. Studies of need for various types of programs—14 percent.
5. Cost-effect analysis—14 percent.
6. General data needed by the administration from time to time—13 percent.
7. Community impact reports—effect of programs on community attitudes and support—13 percent.
8. Assessment of outcomes of individual and/or group treatment—11 percent.
9. Assessment of effect, the outcomes or influences of various types of programs on clients or patients—10 percent.
10. Consultation to other persons engaged in program evaluation—9 percent.
11. Administration and/or supervision of program evaluation activities done by others—7 percent.[4]

Standards for the Evaluator's Work

Administrators and practitioners can look at the evaluator's work with two standards in mind. First, they can consider the reliability, consistency, or repeatability of the findings, and second, they can look for evidence of the validity or correctness of these findings, as shown by successful predictions. The first idea means that one looks at whether the evaluator's reports are in agreement with other information about the topic at hand, whether the report is a need study, a management information system, or the comparative cost of various services. The second means one must make predictions on the basis of the evaluator's work and then note whether events agree with predictions. Looking at the work of evaluators in this manner does not require technical knowledge of evaluation methodology, and as described in the remainder of this section, it should be an activity that every administrator and practitioner is able to carry out.

Some examples of how the work of evaluators can be evaluated by means of these standards are given here. In reports of agency needs, for instance, comparisons can be made of findings from different methods of determining needs. A community survey, in which a sample of residents are sent a questionnaire by mail or are interviewed, is favored by many evaluators. The community forum, in which a group of residents meet at various localities to discuss needs, is another method. Social indicators make use of already collected data, such as economic statistics, divorce rates, criminal justice data, or other evidence of social problems and breakdown. These latter are considered by many evaluators to be the best and cheapest way to measure needs.

Further possibility exists for comparison of findings even when the agency cannot afford the resources to carry out a needs study by more than one method. Persons in the agency who have a long acquaintence with the community often have "arm-chair" estimates of needs.

When the findings of a needs study by one of the three methods above differ from one another, or when one of these methods differs from "arm-chair" estimates, some investigation is warranted.

There is obviously some danger in discarding an evaluator's work because it does not agree with previous information. Differences in reports of evaluators or in the estimates made by persons who know the situation may be explained because of differences in the time the information is obtained, because different localities are studied, or because the source of data is different. Obviously, needs may change from time to time. This is true of other situations investigated by the evaluation. Sometimes an evaluator will obtain information from one locality, whereas other available data are from a different locality. The fact that social indicators often are available only from different geographical areas tends to aggravate this problem. School districts are seldom contiguous with police districts or criminal justice areas, political subdivisions frequently represent different geographical areas from those used in collecting census material, and so on.

Inconsistency in reports of evaluators or lack of agreement with other estimates also may be due to methods of data collection. A community forum may be dominated by a social action group so that the needs expressed are biased in their direction. Data collected through interviews often can be different from that obtained by mail questionnaires. When differences in evaluator's reports or lack of agreement with other estimates are found, further work by the evaluator may be necessary.

Need studies also may be used as an example of whether an evaluator's report permits successful prediction. A need study provides data showing disproportionate service needs from various sections of the community. One then has information on relative needs. If service is provided proportionate to these needs, and a later need study is carried out, it should find essentially equal needs (if service requirements have been met). Areas of high need will have received the most service and areas of low need will have received the least service, and after the passage of time, needs should be reduced and relatively equalized in all areas. Again, when predictions do not eventuate, further study of why this has occured is necessary.

Another example of how the guidelines mentioned above may be used is the cost-effect study. Evaluators frequently are asked to engage in a study of the relative costs of various kinds of service. When the data show that the costs of a certain service are widely different from previous estimates, even though the previous estimates may have been based on more subjective reports, some examination should be made of the evaluator's report. When the findings on the costs of various kinds of service are similar to previous data, experience has shown that this kind of consistency (assuming the caveats mentioned above that affect consistency have been considered) is likely to result in acccurate predictions.

Further, when the findings from one cost-effect study are different from another, the administrator may again test validity by the success of prediction. Services may be changed and costs and effects studied to see if the changes are as predicted. For example, one report may suggest that costs can be reduced and the same effect maintained by substituting group therapy for individual therapy, while another report may show an opposite viewpoint (in the mental health field, this particular issue is one which is far from settled and depends on many other variables). The administrator may increase group therapy in one satellite clinic and increase individual therapy in another, and then ask the evaluator to determine in which area costs have decreased (while at the same time asking the evaluator to allow for other things in these areas that might influence findings).

The evaluator may help the individual therapist learn how he or she is helping clients. If the evaluator's results are different from subjective judgment, the therapist may raise questions as to why this occurs. Goal Attainment Scaling is one method by which the evaluator may assist the therapist in setting operationalized and measurable goals, but the therapist must participate in helping to keep these realistic.[5]

The findings from Goal Attainment Scaling may show that goals have been exceeded in one case, or not reached in another (and a deviation either positive or negative must be considered in applying the guideline of consistency). In either case, the test of prediction can be applied. The individual therapist can ask the evaluator to obtain follow-up information from clients. If goals have been met or exceeded, one would expect the follow-up to show that persons were better able to work or maintain their home, stay out of the hospital longer, or in other ways show a behavioral improvement. The follow-up also should show whether later behavior is as predicted when goals are not met. In either case, the evaluator's work will have been validated. If not, the therapist and evaluator then need to work together.

Similar use of consistency in evaluator's reports and validation of predictions of success can be applied to other work of the evaluator mentioned above. Despite the lack of perfection of the evaluator's work and the fact that it remains something of an art as well as a science, these guidelines offer practical ways in which the mental health administrator and practitioner can apply some standards to the product of an evaluator's work.

Uses for the Evaluator's Products

The utility of evaluation can be improved if administrators, program managers, supervisors, and service providers are knowledgeable about possibilities. Cox has referred to the apparent underutilization of evaluation.[6] Earlier writings implied that the picture was bleak. More recent works by Patton, and Davis and Salasin suggest that utilization occurs more extensively than the earlier literature indicated, though not immediately.[7] The work of evaluators thus may require time to be ingested into the administrator's and staff's thinking and the agency's actions. Weiss, Glaser and Taylor,[8] and the National Institute of Mental Health[9] have focussed on how to increase the use of evaluation.

Administrators can look for certain criteria that make the work of evaluators more useful. Is the study focussed on a specific programmatic aspect of the center? Is the study timely? Does it aid in planning the district, state, or regional program proposal? Does the data analysis provide information regarding the cost of the center's operation, utilization rates by catchment area residents, availability, awareness, acceptability, and accessibility of services? Evaluations that provide positive answers to these questions are more likely to be useful than those that do not.

The evaluator's output can be used by an agency from the time the organization is planned until the time it closes its doors. In the beginning are studies of need; at the end, the evaluator may conduct studies indicating what other organizations can take over functions. In between, the evaluator can show what is happening in the agency, how clients are affected, and what quality and quantity of services are provided at what cost. The latter often are called monitoring activities and are sometimes the most important and frequent uses of the evaluator's work once the agency is operating (see the list on p. 43). These monitoring services may be particularly useful to practitioners to show how their various activities such as consultation and education, and activities with groups and individuals compare, so that changes in practice can be made.

Progressive administrators and program managers see the evaluator's work as a tool that can be used to assist them in this process of monitoring the organization, its activities, and their effectiveness. Program evaluation necessitates a systematic set of data collection and analysis activities undertaken to determine the value of a program in order to aid management, program planning, staff training, public accountability, retention, and promotion.

These monitoring activities can help the administrator or program manager see the relative quality and quantity of work produced by each service provider, and by each clerical staff member. Since data on the time and effort spent on various activities are available, inefficiencies can be found and corrected. Service providers can find guidance on why training is needed, how they can utilize their time more effectively, and what focus and emphasis they need to place on their work.

Mintzberg suggested that managers prefer action. The manager is interested in current information relevant to immediate events rather than with routine or regular reports. In fact, Mintzberg argued that "the pressure of the managerial job does not encourage the development of reflective planners . . . the job breeds adaptive information-manipulators who prefer the line, concrete situation. The manager works in an environment of stimulus-response, and he develops in his work a clear preference of line action."[10] Evaluations that offer recommendations, especially timely ones, can be used when specific decisions have to be made, and are usually highly valued by administrators in the decision-making processes. A needs assessment study which includes recommendations so that administrators or program planners will have up-to-date information at the beginning of the program year is one example of timely evaluation activity.

Administrators can use evaluation output to find alternate ways for the program to become more effective and efficient. This means, however, that evaluators' work must not only provide comparison of findings, but must suggest courses of action. Studies that reveal negative findings are sometimes ignored by managers because they are not helpful in suggesting desirable changes. Whether the manager is the creative, controlling master of his or her organization's fate[11] or "the puppet . . . with hundreds of people pulling the strings and forcing him to act one way or another,"[12] the manager has some freedom to turn the activities in which he or she must engage to the organization's advantage. Evaluation—even negative findings—that suggest unexpected changes, can help the administrator perform his or her task.

The interrelationship between internal, external, and transactional data analysis can be used to deal with all the issues of accountability, such as fiscal matters, clients, programs, service providers, and managerial activities. Every community mental health center has a management information system (MIS), though some managers are unaware of this fact. Frequently, administrators assign the task of upgrading the present MIS or designing a comprehensive MIS to the evaluator. The complexity of such an assignment is often misunderstood by management. The evaluator whose skills, knowledge, and competence are such that they help the manager develop an accountability mechanism usually has stood the severest test from an administrative point of view. Data provided by the center's MIS and the quality of the evaluator's work will be enhanced by proper development of the system.

Answers to these interrelationship questions are of use to service providers as well as managers. Mental health center staff can use the internal information produced within the center, such as patient data, cost data, staff activities data, and so on to understand their own role.

External information such as demographic characteristics of the catchment area population, social area analysis data, mental health needs of the catchment area, and so on have relevance to the activities of each service provided. Transactional information describing what happens between the center and other systems can be used by staff to understand what happens between their activities and clients, in consultations with other agencies, and in terms of community change.

Most community mental health centers have to design programs to meet district, state, and regional plans. The work of evaluators can be helpful in clearly stating program goals and objectives for the total organization and for each program or sevice area. This type of evaluation activity is especially needed in contemporary community mental health centers because some administrators, by virtue of their training, do not see themselves as needing to be involved with organizational planning or as accountable for the achievement of organizational objectives.[13] Since one of the primary responsibilities of an administrator is the continuing viability of the agency, he or she must include planning as one of his or her most important functions.[14] Service providers also must be involved in planning.

One often overlooked use of the evaluator's work is its implications for program planning to meet the needs of minority group members and other "high-risk" groups such as lower socioeconomic classes, children, and the aged. In addition to the planning aspects to determine programmatic needs of these groups, there are monitoring activities required by state and federal funding bodies to ensure that mental health services are available, accessible, and acceptable to racial minorities in the center's catchment area.

Evaluators' work that focuses on awareness of services, psychological accessibility, and clients' satisfaction with services is useful to administrators, program managers, and service providers in public relations and mental health education activities. Questions about programs and services raised by the media and by individuals can be answered with "hard data," that is, with information provided by the evaluator that is of known reliability and validity. For example, when concern is voiced about whether various groups are receiving an equitable share of services, the evaluator's data can provide definitive answers.

Data analysis is only one of the many inputs that administrators consider in decision making. They must weigh other issues such as political ones, the funding situation, personnel availability, and other programmatic considerations. The evaluator's findings often can throw light on these issues. Some major decisions are made on the basis of budgetary requirements, grant proposal considerations, the political climate, and other relevant data.

The use of the evaluator's work is enhanced if there is a close association between the administrator and evaluator. The administrator who provides the evaluator frequent access to himself or herself enhances the opportunity for verbal reports. Mintzberg has suggested that managers prefer verbal communication, which exchanges more information, takes less time to prepare, and requires a shorter turnaround time.[15] Where there is a close association and/or frequent exchanges between the administrator and evaluator, the latter learns the important questions, decisions, policies, and external pressures faced by the administrator. Written reports from the conferences can then be used in dealing with boards, committees, and so on, with the data supporting the agency's point of view or presenting alternatives.

The manager or administrator sets the tone for the standards and provides support for and use of the evaluator's work. The professional responsibility rests on the shoulders of administrators to use the resources at their command in an efficient way in order to provide a high quality of service to clients. If top administration lets it be known that the work of the evaluator is an important tool in managing the total center's operation, that view will trickle down to program managers, supervisors, service providers, and clients. In turn, the evaluator's work should become increasingly useful.

NOTES

1. One of the best guides for an administrator, service provider, or beginning evaluator to these varied activities and "how" they may be carried out is an NIMH document, *A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers* (Washington, D. C.: U. S. Government Printing Office, 1976).

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4. Harris K. Goldstein, unpublished document. Further details may be obtained by writing to the author.

5. See Susan McCree, Geoffrey Garwick, and Joan Brintnall, *Bibliography of Goal Attainment Scaling* (Minneapolis, Minn.: Program Evaluation Resource Center, 1971).

6. Gary B. Cox, "Managerial Style Implications for the Utilization of Program Evaluation Information," *Evaluation Quarterly*, Vol. 1 (August 1977), p. 499.

7. M.O. Patton, *In Search of Impact: An Analysis of the Utilization of Federal Evaluation Research* (Minneapolis, Minn.: University of Minnesota Center for Social Research, 1975); and H.R. Davis and S.E. Salasin, "The Utilization of Evaluation," in *Handbook for Evaluation Research*, ed. E.L. Struening and M. Suttentag (Beverly Hills, Calif.: Sage Publications, 1975).

8. C.H. Weiss, "Between the Cup and the Lip" *Evaluation*, Vol. 1 (1973), pp. 49-55; and E.M. Glaser and S.H. Taylor, "Factors Influencing the Success for Research," *American Psychologist*, Vol. 28 (1973), pp. 140-46.

9. National Institute of Mental Health, *Planning for Creative Change in Mental Health Services: A Distillation of Principles on Research Utilization* (Washington, D.C.: Department of Health, Education and Welfare, 1971).

10. Henry Mintzberg, *The Nature of Managerial Work* (New York: Harper and Row, 1973), p. 38.

11. P.F. Drucker, *The Practice of Management* (New York: Harper and Row, 1954).

12. S. Carlson, *Executive Behavior* (Stockholm: Stromberg, 1951).

13. Jack F. Wilder and Sutherland Miller, "Management Information," in *Administration of Mental Health Service*, ed. S. Feldman (Springfield, Ill.: Charles C. Thomas, 1973), p. 136.

14. *Ibid.*, p. 3.

15. Mintzberg, *op. cit.*

V

An Approach to Social Work Practice In Community Mental Health

BY ARTHUR J. KATZ

In examining a field of service such as community mental health, a field fraught with ideological and methodological quagmires, the goal of advancing ideas to help establish a rational and clear framework for social work practice seems a most worthy one. Such a task takes on significant proportions when the conflicts and confusions about goals, objectives, and program orientation appear so prominently. In considering an approach to social work practice in community mental health, it is useful initially to note that as a primary profession within that system and one which delivers a substantial amount of services,[1] social work shares a similar history of ideological confusion and faces parallel issues.[2] Moreover, it is important to recall that social work's historical experience in dealing with some of these ideological issues, albeit not entirely with success, may offer valuable guidance to the community mental health system and for the place of social work within it.

The development of such an approach may be of value either to those already in the system or those planning to enter. It may be helpful to agency administrators and boards of directors in their efforts to achieve sound deployment of differentially qualified professional staff. Social work educators in MSW and BSW programs also may find it useful as they search for ways to distinguish between generalist and specialist functions of social workers in community mental health agencies. Implications for curriculum building are evident. Most importantly, it is hoped that with sounder utilization of social workers in community mental health, more effective service to clients will result.

There are interconnected questions that must be addressed in developing such a working frame of reference. At the broadest level, the ideological orientation of the community mental health system itself should be examined. The current and past investment in the medical practice model needs to be carefully assessed in light of the original community mental health philosophic commitment to the goal of prevention, which continuously has proven to be elusive. The questions that need to be raised about the medical practice model as it has emerged in community mental health, however, go beyond its inability to successfully produce meaningful programs of prevention on any but the tertiary level.[3] Equally significant questions about the medical practice model are related to such issues as effective and efficient service delivery, accountability, cost of services, and utilization of different manpower resources. The planning and administration of critical services to chronic patients in community-based programs is another. The clinical orientation of much of social work practice in community mental health, with its strong psychotherapeutic function deriving from medical practice identity, also bears sharp scrutiny.

Social work practice, oriented to a narrow interpretation of the clinical function, operates to constrain possibilities for social workers to engage the immediate and intermediate environments as levels of intervention. A frame of reference therefore must be grounded in the more complex appreciation of environmental relationships to which the profession is heir.

Nor can social work ignore such critical institutional forces as economics and politics on the "mega-environment" level. These are key forces that perhaps have potential to engender systemic change in lower-level environments. The latter is particularly significant in considering mental health needs of aggregate populations and the prevention objectives that flow from such a conceptualization.

The notion that community mental health services in this nation are beset with deep problems comes as no surprise to those who have followed the fortunes of society's attempt to maintain and improve the well-being of its citizens.[4] The term "mental health" has been with us for at least 75 years. "Community mental health" as a formal, institutionalized concept has existed for no more than 20 years.[5] Although a variety of definitions are available in the literature, none have been accepted as definitive or universal. The community mental health services system may be described most generally as that organized, interrelated constellation of direct and indirect community services that contribute to the maintenance and improvement of the emotional and/or mental health of citizens in a specific geographic area. This system also must work toward prevention of mental illness. Differential definitions reflect various levels of inclusiveness.

The Council on Social Work Education's recent study identified 14 different types of agencies involved in this system and grouped them under four major headings: (1) community mental health centers, (2) hospital settings, (3) freestanding clinics and components of other center services, and (4) agencies providing indirect services (mental health planning, coordination, and education).[6] To these can be added a fifth—community network agencies, such as the public social services income maintenance programs, voluntary social service and religious organizations, and other public social utilities, such as the police, public health, and schools. In addition, one also might include the public and private employment sectors that connect with the community mental health system at critical junctures.[7]

Such a description makes it difficult, if not impossible, to exclude any aspect of social living from the community mental health system. In the opinion of some, exactly such integration with all other social systems is called for. However, one logically can divide the first four groupings from the fifth by considering the first four as primary to community mental health and the fifth as secondary. Unlike the fifth, the first four specify the provision of mental health services as their principal goal. There are some who argue against any such dichotomy and would insist that the community network services be viewed as an integral part of the primary sector of the system. They reason that such a lack of integral identity has in the past made it difficult to implement a meaningful delivery of community mental health services. There are others, however, who claim that the community network agencies should not even be considered as secondary segments of the community mental health system, since they belong in a totally different system—sometimes identified as human services.

This issue is not an irrelevant one for social work. Although many social workers currently function comfortably in agencies of the first four groupings, they may have substantial and perhaps even greater contributions to make to community mental health in the community network agencies. These contributions would derive from the special mission and competence of social work in such functions as "integration" and "brokerage." This issue seems to become even more significant as the processes of deinstitutionalization leading to community-based programs continue to gain prominence.

It may be argued that the community mental health services that have emerged in the past 15 years are reflective of a marked duality of purpose (direct treatment vs. prevention) that never has been resolved. This duality often has led to a dichotomy in community mental health agency program objectives and service activities.[8] It also has resulted in a blurring and confusing of roles in different professions. In some cases this dichotomy has led to a level of dysfunction that has all but destroyed the ability of agencies to operate effectively. In other cases the dysfunction either has been avoided or overcome. In general, however, for a variety of ideological, financial, political, or professional reasons, agencies have chosen to take an evasive view in response to this duality. They have chosen to focus on one aspect of this dilemma and have functioned primarily with a unilateral orientation. This single focus usually has been reflected in direct treatment of identified problems of mental, emotional, or social disturbance as presented by the individual. The second focus in the duality—that of work toward change in community institutions related to the goal of prevention—has been most inadequately engaged. The current ideological reference of most community mental health services may be described as that of "medical practice," which has as its primary orientation, treatment for the purpose of curing identified pathology.

Social work practice historically has struggled with a similar dilemma. Throughout its organized existence of over a century, the profession regularly has moved in cycles from an emphasis on clinical treatment (curing) to that of social reform (institutional change). Currently the emphasis seems to be largely on the clinical treatment orientation. In addition, social work has been engaged in another level of controversial definition, that of clinical practice itself. Some tend to define clinical practice with a narrow perspective, placing the fundamental emphasis on the function of psychotherapy.[9] At the other extreme are those who insist that the classical and traditional definitions of psychotherapy, with their exclusive emphasis on the patient-therapist relationship, are inappropriate and ignore the environmental factors that are an essential ingredient in all social work practice.[10]

Social work professionals engaged in psychotherapy seem capable of bringing to that practice a specialized and unique orientation that encourages the concern for environmental factors. In doing so, a methodological approach is produced that may be superior to psychotherapy as practiced by other professions. Such an interpretation seems not only possible but highly desirable. Traditional psychotherapy without an environmental focus may be a valid modality in community mental health, but is hardly one that logically can be identified as social work practice.

Clinical social work practice must be perceived in a significantly broader context than the psychotherapy function, since it encompasses much more. One recognizes that social workers can and should perform psychotherapeutic functions in their clinical practice, but it should not be their exclusive function. Clinical *social work* practice is a generic designation that must include functions unique to the profession. Traditional psychotherapy itself is not such a unique function. Some examples that are, include: environmental modification, development of new resources, establishment of links and facilitating interaction between people and resources, promoting effective and humane operation of resource systems, and promoting interaction between these systems on behalf of clients.[11] Some of these can be considered part of clinical practice, but only using a broad definition. Helping clients develop internal problem-solving and coping capacities also is an integral function of social work.

One question which the profession currently has not answered satisfactorily, but which is nonetheless worth considering, is how to define the nature of specialization in practice. One effort underway at this time seems to reject the notion of specialization by methodological focus.[12] The notion of a "clinical social work specialty" offers a great many conceptual problems, since the broad definition of clinical practice would place that term in a superordinate position to any specific method and would probably apply to most social work activities; it cannot be considered a specialty any more than can "clinical medicine" for physicians.

Are social workers, then, logically justified in specializing in psychotherapy, given the view that an expanded definition to environmental dimensions is possible? The answer is moot. Social workers will continue to practice functionally as psychotherapists. There is no more reason to question that function than there is to question that of social workers as administrators, politicians, or personnel specialists in industry. Does it matter that other professions also engage traditionally in that function and that there is a confusion of identity and in efficient manpower deployment? Yes, it does matter, yet there are many other fields of practice in which social work confronts similar issues. The caveat for the social worker in the practice of psychotherapy is that it clearly should reflect a social work (environmental) perspective and that the practice not be limited solely to the psychotherapeutic function.

Given the state of ideological conflict and confusion in community mental health and in the profession of social work regarding these important issues, it seems understandable that social work practice in community mental health suffers from a lack of clarity about its primary function. The profession therefore must take direct leadership to help resolve the conflicts in both arenas. Certainly the profession has the right and obligation to further an ideological direction and position for the practice of its own members. Can it presume such leadership for an entire field of practice, one in which social workers represent only one of four primary professions? The answer almost of necessity is "yes."

While it may seem presumptious to extend such leadership to the entire field of practice, social work is in a particularly visible position, considering that the number of social workers in the community mental health system is substantial. Eighteen percent of all full-time professional patient care staff in mental health facilities in the United States in 1974 were social workers, second only to registered nurses, who accounted for 29 percent. Social work also represents a high proportion of full-time employees (70 percent), second only to nurses (77 percent).[13] However, registered nurse positions are largely concentrated at inpatient facilities (only 2 percent were located in outpatient psychiatric clinics and 10 percent in federally funded community mental health centers). In contrast, 22 percent of social work positions were concentrated in outpatient clinics and 20 percent in federally funded community mental health centers. This suggests a potentially higher orientation of the social work profession to the "community" context of mental health. The 1974 data identified 27,042 social work positions, 19,649 at the MSW level or above (72 percent) and 7,573 below the MSW level (28 percent).[14]

In 1976 there were 31,212 social work positions within the community mental health system. This number is ten times that of 1950, 50 percent greater than in 1970, and 20 percent larger than in 1974. Seventy-three percent of the total social work positions in 1976 were at the MSW level. It also is estimated that another 12,000 social workers are in full- or part-time private practice, which represents an additional amount of social work resources in the total community mental health system.[15] The social work contribution to the mental health enterprise is undeniably a substantial one. The stake of social work in the ideological direction of community mental health inevitably must influence social work practice in that system and should be no less substantial. Which direction, therefore, should the profession support for the community mental health system?

One set of choices poses the medical practice against the human services model. Each of these utilizes different program priorities and personnel patterns. Both, however, incorporate contributions from different sources. The medical practice model is quite familiar to most. The "human services" ideology, according to Baker, would relate to the following basic themes as guides to service delivery.[16]

1. Systemic integration. (Linking and integrating the various caregiving agencies.)

2. Comprehensiveness and accessibility. (Inclusive services available to all without geographic or administrative barriers.)
3. Problems in living. (Focus on the fit between the person and the environment.)
4. Generic helping activities. (Universal helping activity of caregivers transcending professional boundaries.)
5. Service provider accountability. (Responsibility to clients and to the public at large.)

Schulberg maintained that these human services themes have emerged out of community mental health ideology, although he thought they also might stem "from other societal concerns."[17] As a psychologist he attributed no connection to these themes and basic principles of social work practice. Yet some of these themes directly reflect social work conceptualization of its practice over the last 50 years.

Consider the first theme, "systemic integration." The concept of linking and integrating various caregiving agencies is without question a classic social work practice function. Pincus and Minahan included in their five major objectives of social work practice the following: "Facilitate ongoing interactions between resource systems to enable them to work together effectively."[18]

The third theme, "problems in living," placed emphasis on the fit between person and environment. The report of the Milford Conference of 1929 stated: "The distinguishing concern of social casework is the capacity of the individual to organize normal social activities in a given environment . . . to develop in the individual the fullest possible capacity for self-maintenance in a social group."[19] The working definition of social work practice further explicated this concept: "Through this relationship the practitioner facilitates interaction between the individual and his social environment, with a continuing awareness of the reciprocal effects of one upon the other."[20]

Thus the emerging human services model for community mental health has integral links with social work ideology.

The medical practice model is characterized by medical leadership and mandates medical responsibility for all mental health services in the community, placing it completely within the "health system." The human services model takes the position that the mental health facility is merely one of many community resources that can determine how to deliver services and that leadership and responsibility is by no means exclusively medical.[21] The human services model offers, therefore, a much broader perspective for service delivery and opportunity for linkage development and resource integration within the formal agency structure, as well as with the informal "natural network."[22]

The following schema may help illustrate one view of the differences between the medical practice and the human services models for community mental health service delivery.

Community Mental Health Service System: Comparative Schema

	Medical Practice	*Human Services*
Ideological Focus	Individual Health	Community Well-Being
Goal	Restoration to Equilibrium (curing)	Curing, Caring, Preventing
Change Focus	Intrapersonal, Interpersonal	Intrapersonal, Interpersonal, Institutional
Intervention Targets	Individual, Family, Small Group	Individual, Family, Small Group, Institutional
Type of Service	Direct Treatment	Direct Treatment, Indirect Services
Methods	Clinical, Case Consultation	Clinical, Administration, Community Organization, Case and Program Consultation, Institutional Systems Change
Clientele	(Patients) Selective, Identified Pathology Persons	(Clients) Identified problem Persons, Community Neighborhoods, Catchment Area Population
Service Deliverers	Medical practitioners (primary), Allied Health Personnel (secondary)	All Qualified Mental Health Personnel, Including Medical Practitioners
Policy Determiners	Medical Professionals	Multidisciplined Professionals, Community-Based Representatives and Leaders

It seems incumbent upon the leadership in social work to support and advocate for the human services approach in community mental health and encourage a move away from the dominance of the medical practice model. Obviously this challenge will not go uncontested. The influence of medical practice (psychiatry) on high governmental levels, like ADAMHA and NIMH, are clearly in evidence.

The American Psychiatric Association has become extremely aggressive recently in what they have termed a "battle for professional survival," and are seeking stronger links with the American Medical Association to help extend their political power base. This is related to the challenge to psychiatry by the nonmedical professions. "Dr. Masserman (APA president) also suggested that they push for treatment supremacy over all allied health professionals practicing in the mental health field."[23] In the state of Virginia a recent joint effort by the APA and two Virginia districts resulted in halting a bill in the state legislature that would have provided for direct reimbursement by insurance companies to social workers.[24]

In considering this issue of mental health and human services, the President's Commission on Mental Health Report came to some confusing conclusions. It first defined human services as including mental health along with personal health, public health, social services, and so on. However, it also distinguished human services as a system different from health. It then went on to delegate to social services—presumably a part of the human services system—such program areas as rehabilitation and community support of the long-term patient. Yet at the same time it clearly identified mental health as part of the health system:

> Mental health has been and must remain a part of health. However, rehabilitation and community support of the long-term mentally ill is a social service activity which cannot be abandoned by mental health. It is important to distinguish the separate systems while at the same time acknowledging that mental health requires support and linkages to both systems. It has already been noted that certain mental health personnel (especially social workers) carry on many of their activities within other human service systems, thus providing linkage with these systems.[25]

Social workers are then seen as having functions related to mental health in both the health system and the human services system. It is interesting to speculate on the implications of the comment that rehabilitation and community support of long-term mentally ill is a "social service." Have these critical program areas been delegated to social work?

An Approach to Social Work Practice In Community Mental Health

Social work can only contribute effectively to community mental health if it retains its singular and special characteristic. The challenge to social work practice in any special field is that of adapting or modifying its core framework to meet the needs of the special setting without giving up important core values.

One such value is integration. This is simply defined to mean "forming or blending parts into a whole," or "uniting parts." Working with the client as a wholistic person has long been a basic principle of social work practice. Ideally, the profession has striven to understand not some but the total range of factors (external and internal) which impinge upon, affect, determine, and explain the human condition. Simultaneously, practice has attempted to consider how such relevant factors may be modified or changed. The President's Commission on Mental Health Report commented on this core social work function as follows:

> Social work's strength lies in the integrating work it does for clients, families, and communities . . . the overall functions of integrating the client with his family and community, social assessment and social integration are most significant roles which are gaining in importance as the mental health delivery system moves to deinstitutionalization and more community-based services.[26]

Integration implies that the "dual focus" on person environment is not separate. A social worker may begin at either end of the continuum (micro or macro) but must at some point engage the duality. As Briar commented: "No other profession has yet taken as its task the clinical assessment of the social environment in relation to the lives and needs of people."[27] Cooper pointed out that "our profession has always stood at the interface of person and environment . . . social work has often taken as its task the provision of new environments for people whose earlier circumstances failed them . . . "[28] For Morris the key social work function is "creation and management of social environments which will help people to be cared for."[29]

Social workers who practice within the community mental health field are inevitably aware of these ideological references to integration and environment. For a variety of reasons, their work often becomes skewed to the person focus. One reason must be related to the knowledge base about this interface arena: "A tenuous place to be theoretically since no theory has to date effectively spanned this bridge . . . the fine blending of the reciprocal and dynamic relationship between the inner and outer reality remains still to be described and understood."[30]

The second reason seems to be that the skills related to intervention within the larger systems of the environment seem rather insignificant in face of some of these major forces: "The political, social and economic contact of social work practice is often more powerful in its effects upon clients than the explicit skill of the social worker."[31] In addition, these larger environmental settings often hold potential for political complications, which can lead to controversy. Avoidance of such conflict inevitably leads to a selection of a micro-intervention level by the practitioner.

Social work's current functional activity in community mental health clearly points to a heavy preoccupation with the person focus in terms of direct treatment. In 1972, Berg, Reid, and Cohen found that social workers in agencies with a "high" orientation to community mental health spent 46 percent of their time in diagnosis and treatment and 18 percent in community activities. Those in agencies with a "low" orientation spent 60 percent of their time in diagnosis and treatment and 5 percent in community activities.[32]

A 1977 Council on Social Work Education study found that the highest scores, both in range and in mean for functional activity of social workers, were ascribed to the direct service functions. The averaged score for direct service was twice that of indirect service. The three highest ranking functions in the direct service area were diagnostic assessment, case management, and short-term treatment. The three highest ranking functions in the indirect service area were case consultation to other agencies, program consultation to other agencies, and mental health education to the community.[33]

The Council's study also identified a number of major concerns by social work practitioners in community mental health. One was insufficient differentiation between roles and functions of the various levels of social work personnel. Great discomfort was expressed about the lack of clarity regarding uniqueness of social work practice, identifying a need for the profession to clarify and enhance its special identity and image. The observation and concern was expressed that social work practice in community mental health is becoming increasingly oriented to direct treatment, with a similar trend developing in social work education. The commitment to institutional change seems to be disappearing, implying a narrowing of the scope of social work intervention.[34]

Implications for Social Work Education

The Council on Social Work Education's recent study on Community Mental Health Curriculum characterized much of the curriculum content as "diffused," as opposed to "concentrated."[35]

A rationale for diffused rather than concentrated curriculum is based on the resistance by some faculty to the concept of specialization at the MSW level. It is argued that the MSW program should be generic. Specialization training therefore should occur at the post-master's level either in continuing education programs or on the job. Although one cannot argue against a generic core within a two-year MSW curriculum, there is a question about the entire two-year program being so constructed. Translating generic knowledge and skill to a specialized setting should not be entrusted to random and unorganized continuing education activities, nor to those vague experiences known as in-service or on-the-job training. It should be done under the conceptual guidance and direction of an organized curriculum within a school of social work. To view specialization as incorporating new knowledge and skills different from the generic core is an error. Specialization requires an alteration of the generic core in response to the particular needs and demands of a special setting.

A curriculum for specialization in community mental health, therefore, might include new knowledge about settings, but, more importantly, would focus on the development of practice skills based on the concept of an integrated intervention. Such a "specialized" curriculum in the second year of a master's program could only strengthen the commitment to the generic core because it would provide an experiential example. It is difficult to teach the generic base of social work practice without explicit examples. An organized and concentrated focus on community mental health easily could support the teaching of the most generic principles of social work practice. The view by some faculty of community mental health as overly focused on direct treatment, narrow clinical practice, and psychoanalysis is the same error that has been perpetuated in the field.

MSW programs should consider the development of a concentration in community mental health during the second year to include courses with new knowledge content about the setting, and focus practice courses to reflect the adaptation of the core principles to the special community mental health field demands.

In response to Briar's note about clinical assessment of the environment,[36] it is imperative that social work education take as one of its major research tasks the development of new knowledge in this area. Our curricula seem to be in dire need of such new knowledge content.

If indeed the interface area is such a "tenuous" place, it is time that the knowledge bridge be strengthened so that social work's position can be clearly established and understood.

Summary

It seems reasonable to assume that the social work profession, given its significant experience with the environmental focus, can be helpful to the field of community mental health in its struggle to develop program objectives that relate to "person in environment." Such a context is critical to the success of a human services model of service delivery.

In order to be helpful, social workers in community mental health must reassert strongly the view of environmental interaction with clients. Without this special view, social work is limited in its value and has nothing unique to contribute to community mental health.

Maintaining or extending the medical practice model with its heavy emphasis on narrow-based psychotherapy can only result in a continuation and exacerbation of the current dilemma. Social work leadership in community mental health can be exercised best by a clear definition and commitment to practice of its own special and unique perspective. This environmental engagement perspective can be demonstrated most effectively in a human services model for community mental health delivery.

Social work may well be the profession best related to the "community" aspect of community mental health, but social workers face strong pressures to practice the more traditional and narrow clinical forms. We must therefore maintain the critical orientation upon the integrative relationship between person and environment. It is within that relationship that the unique perspective of social work can make a sound contribution to the community's mental health.

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VI

Citizen Participation in Community Mental Health Programs

BY SAMUEL O. MILLER

As evolving and dynamic theoretical frameworks, orientations to the care of the mentally ill periodically have undergone complete transformation, and more frequently slight shifts in their perspective. The characteristics that distinguish each adaptation from its predecessor are not always sharp or explicit, although proponents may engage in vigorous rhetoric regarding such distinctions as they seek to establish the prominence of a particular adaptation. The newest approach, community mental health, has been categorized as the "third mental health revolution."[1]

Such a classification suggests a major deviation from previous traditional mental health efforts, and implies the presence of novel and original features. The details of the debate regarding this conceptualization are available elsewhere and this discussion will not take sides in that dispute. Suffice it to say that there is considerable agreement on several characteristics among those defining and describing community mental health. Among other characteristics, they identify efforts to provide and coordinate comprehensive services and continuity of care; overriding concerns for the prevention of mental illness above and beyond rehabilitation of the mentally ill; the differential utilization of mental health manpower, including indigenous paraprofessionals; and the goal of involving the community and consumers in strategic ways.

Citizen Participation: Defined and Described

This chapter will focus on one of those distinguishing characteristics, namely citizen participation. For the purposes of this discussion, citizen participation is defined as the process whereby members of a community mental health center's catchment area, including former and potential utilizers of its services, are actively involved in the development, decision making, and ongoing administration of the center's program. When fully achieved, such participation serves to increase the flexibility, responsiveness, and accountability of service-providers and service delivery, and increases the possibility that potential consumers and the public at large will become better informed regarding the availability, nature, and appropriate use of services.

Certain assumptions underlying this definition and the discussion to follow should be made explicit. First, this definition simultaneously conceptualizes citizen participation as a process and a goal. As a process it is the dynamic transaction that professionals stimulate and nuture and through which the citizen participants make known their views and expectations, develop policies, express objections to center positions, make decisions, evaluate program outcomes, and hold staff and administration accountable. The perspective presented here also conceives of citizen participation as an interim goal achieved in order to accomplish such high-level goals as flexibility and relevancy of services, the prevention of individual and group alienation, more equitable distribution of power, and the development of leadership among disadvantaged groups.

In the second place, the development and nurturance of citizen participation in the programs of community mental health centers—admittedly an interdisciplinary enterprise—is by no means the sole responsibility of social workers. Yet the social work profession, by virtue of its recognition of the therapeutic value of participation, its unique commitment to self-determination, its historical association with disadvantaged groups as advocate and principal service-provider, and its adherence to democratic ideals, has a unique stake in and responsibility for enhancing its viability within this social system. Indeed, some form of citizen and consumer participation long has been an integral part of social work programs and policies. Similarly, the development of the specialized knowledge and skill requisite for maximizing citizen participation has been a major (albeit not fully realized) concern of the social work profession. One can honestly ask: If social workers do not support citizen participation, then who (or which professional group) will do so?

Third, the nature of consumer participation in community mental health is undoubtedly complex and its expression can and does take a variety of forms. Professionals tend to be enthusiastic advocates of one form or another of consumer participation, as when clients become true coparticipants in decision making regarding "the problem to be worked," in determining and evaluating treatment goals, and as active members in therapeutic communities. In these contexts, the participation is controlled in toto by therapeutic objectives, and the benefits of such participation accrue principally to the individual or immediate group members. Similarly, it is the rare professional who is able to acknowledge fully the contribution or respond to the participant without primary consideration of his or her patient status and the implications thereof. Citizen participation, as will be emphasized in this chapter, refers to the decision making by and influence of citizens in programmatic technical, policy, and structural areas that have implications far beyond the immediate benefits to the individual participant.

Fourth, in discussions of the participatory process, various terms are used interchangably, contributing to conceptual obfuscation and inhibiting professional action. Thus the adjective may vary from "citizen" to "consumer" to "community," and the noun may be variously "involvement," "participation," or "control." Each term, singly or in tandem, has different connotations for those concerned with the issues, and equally diverse implications for their response. For example, as indicated above, the notion of "consumer" immediately brings to mind the participant's current or past patient status, and control invariably raises the spectre of uninformed individuals making irresponsible decisions and taking irreversible actions contrary to their, the profession's, or the organization's best interests.

In this chapter, the choice is made to emphasize the term "citizen participation," cognizant that current and former consumers as well as members of the community all are citizens, irrespective of their mental status or current residence. Coupling "citizen" with the noun "participation' speaks cogently to the recognized rights of individuals to have a say in the affairs of organizations that concern them. The discussion assumes that consumers are distinguished sometimes by the urgency with which they speak, and always by the personal proximity to the issue around which they participate. Many consumers evolve—through the increasing breadth of their concerns regarding mental health issues—into concerned, vocal citizens advocating for benefits that may have no immediate impact on them or their interests. Participation also connotes an ongoing process, without *a priori* specifications of its quality or outcome.

Historical Development of the Concept of Participation

Current discussion to the contrary, there has been a long tradition of community and citizen participation in the field of mental health. As a process it has evolved through three principal developmental stages. The current preoccupation however, has arisen with systematic changes in the identity of the participants, the rationale for such participation, the methods utilized by the participants, and the ultimate goals of the citizens who participate.

Caplan noted that as early as the 1830s and 1840s a positive alliance existed between alienists (psychiatrists) and laypeople that fostered the development and expansion of moral treatment, perhaps the first organized approach to the care of the mentally ill.[2] A second by-product of this alliance was the increased acceptance of public responsibility for those who were unfortunate enough to become mentally ill. This positive alliance lasted for decades and involved an interchange among equals between the alienists and local citizens, who were usually wealthy and from the upper social class. The psychiatrists of that period:

> attempted to lower barriers between the mental hospital and the community by efforts to improve public attitudes toward insanity. It was hoped to ease the treatment of those who were or had been mentally ill, thus facilitating their reabsorption into the community as well as alleviating mistreatment of unhospitalized cases and to encourage early case finding, thus contributing to the highest possible rate of curability.[3]

It was typical for citizens—motivated by religious or reformist objectives—to attend hospital functions and socialize with patients, to provide board and room for some of them, to identify relatives and other citizens at risk, and, in general, to behave in ways that systematically reduced the distance between themselves and the patients.

It was such proximity that gave rise to one of the most famous citizen participants, Dorothea Dix. Her campaign to increase the number of public mental hospitals in the country, and her efforts as an untiring advocate for better care for the mentally ill are legendary, as is her almost-successful effort to achieve national legislation, thus cementing the notion of public care for the mentally ill. Although she was highly critical of the institutions and their practices, there was, nevertheless, a mutual respect between her and the superintendents of those institutions, undoubtedly because of the similarity in their class and social status.

The next major stage in the development of this concept was not characterized by such harmony, but had as its outcome additional improvements in the quality of patient care. Lay reformers who succeeded Dorothea Dix were more vociferous in their outcry against poor patient management, corruption, and the self-aggrandizement of the professionals and superintendents. They made numerous accusations about the limited scientific advancements, which tended to increase the alienation between the public and the professionals. This period reached its zenith with the publication of *A Mind That Found Itself* by Clifford Beers[4] and the subsequent development of the National Committee for Mental Hygiene. Allied with liberal professionals, aroused citizens and—for the first time—actual patients advocated for appropriate.legislation and more humane treatment of the mentally ill. In the ensuing years, citizen participation became institutionalized in its current socially and professionally acceptable forms—that is, citizens as board members, fund raisers and contributors, volunteers, and advocates for legislation and other changes.

Although there were variations on the major theme, there was a remarkable similarity in the thrust of lay participation during these early historical phases. In almost every case, the majority of participants were representatives of the upper and middle classes and of the dominant ethnic group. The rationale underlying their participation flowed from the personal, social, and economic benefits accruable to them; their tactics and roles were within the boundaries accepted by professionals; and their goals were to maintain programs or organizations or to increase the effectiveness or efficiency of services. These participants and their objectives continue to be a dominant force on the professional scene, but in recent decades citizen participation has achieved new prominence.

The current stage in the evolution of citizen participation is unique in two major respects. First, a new wave of actors—primarily representatives of the poor and of racial and cultural minorities—emerged. These new participants, buttressed by previous involvement in community organizations or national movements, knowledgeable and concerned about community dynamics, needs, and life-styles, and frequently possessing a sensitivity born out of their personal experiences, offered a heretofore unavailable input. They brought, simultaneously, an articulated interest in changing programs to meet the needs and goals as defined by the community they represented. For some, participation frequently developed from an initial therapeutic objective, but for most it was sociopolitically inspired. These participants assumed that any methods capable of shifting the design, operation, and evaluation of programs that served them were valid.

In the second respect, previous professional developments had resulted in documented societal support and legal precedents for lay citizens making contributions to decision making on issues affecting or of import to them. However, for the first time citizen participation was translated into organizational goals responsive to repeatedly enacted federal statutes and administrative regulations requiring citizen participation in programs where federal funds were used. Thus prior to the Community Mental Health Act of 1963, such politically created efforts as Mobilization for Youth, the President's Committee on Juvenile Delinquency, and the Office of Economic Opportunity laid the groundwork for a significant departure from the traditional interactions between professionals and concerned citizens.

The most recent legislation, the 1975 amendment to the Community Mental Health Center Act, is very specific regarding the need for citizen involvement in all levels of mental health decision making. Title II, Section 206 explicitly states that citizens shall be involved not only in planning and operation but also in review of services for the expressed purpose of insuring that such services are developed in response to articulated needs.[5]

In contrast to previous periods when professionals welcomed lay participation, there has not been overwhelming enthusiasm among social workers or other mental health professionals for these new participants, their methods, or their objectives. Rather, they often have been met with token acceptance and, worse, with suspicion and resistance—attitudes that appear to be related on the one hand to a general estrangement between the professional, the poor, and members of racial and cultural minorities,[6] and on the other, to confusion and concern among professionals regarding citizen participation as a process and a goal.

Current State of Knowledge and Practice

Irrespective of the reasons for the limited enthusiasm given to current citizen participation, one critical result has been the minimal development of new knowledge or the organization of existing knowledge to inform the identification of problems, the clarification of objectives, and the specification of practice principles and techniques relevant to citizen participation. In response to criticism, there have been periodic and frequently genuine efforts to increase the accessibility and relevance of services to those who need them most. Consequently, we have learned much, and although there is a long way to go, the development of knowledge and skill has been phenomenal. A more insidious deterrent to knowledge building and practice development (and consequently to the enhancement of the participatory process itself) is the concern of certain professionals that any form of citizen participation will inevitably lead to community control and concomitant problems for professionals (if not complete loss of control by them).[7]

It is clear that the current uneven approach to citizen participation in community mental health can only be remedied by changes on two major fronts: in the attitudes, knowledge, and strategies of professionals with respect to the participatory process, and in the competence with which citizen participants carry out their responsibilities.

The social work profession has taken an initial step toward the solution of the professional dilemma by virtue of the stance taken in the National Association of Social Worker's position statement on community mental health.[8] In this document, the Committee on Community Mental Health identified several areas in which communities must make decisions. These include such vital subjects as program priorities, deployment of resources, interaction between staff and its community board, and the community's efforts to solve social problems and to cope with social dysfunction. While it is well-known that attitudinal changes do not occur simply by programmatic or professional fiat, it is instructive that the committee also warned against practitioners becoming "isolated professional elite(s) who regard themselves as the proprietors of highly specialized establishment." What is required now is for individual social workers to gain an informed appreciation of the inherent value of citizen participation, recognizing that as a process it is not automatically in conflict with professional objectives. Rather, it is more likely that the process will be compatible with, and supportive of efforts expended to achieve distinct objectives and to fulfill the potential of the community mental health movement.

The knowledge and skills requiste for purposeful professional actions to stimulate citizen participation and to enhance competent participation, once initiated, are *not,* in my view, discrete or completely unknown quantities. Much in the existing professional knowledge and practice repertoire is applicable to both processes, although, for reasons already indicated, it has not been given concentrated theoretical consideration. On the other hand, few centers—with the notable exception of the Woodlawn Mental Health Center in Chicago—have attempted systematically to involve citizens based on a conceptually defined perspective. As a result, the essential practice issues have not been isolated or articulated in the social work or other mental health literature. Instead, it is replete with examples of the crises, conflicts, and constraints that emerge when citizens have demanded opportunities to participate.[9]

Perhaps the most pressing need at this time is a beginning attempt to organize some of our knowledge regarding citizen participation. Once the knowledge is organized and articulated, experimentation within schools of social work would naturally follow, both in their regular programs and in continuing education, to effectively train and develop the practice skills of current students and graduates; as would the desirable examination of professional attitudes toward the concept and process of citizen participation.

Suggested Teaching-Learning Areas

There seems to be almost no end to the information, knowledge, and skills that practitioners will require for coping with participating citizens. Efforts to instruct practitioners should speak to the attitudinal, cognitive, and behavioral spheres. As schools experiment with this content, there probably will be considerable debate regarding whether this information and knowledge should be imparted in a separate course or dispersed throughout the social work education curriculum. Obviously there is no single correct form to accomplish the educational objectives, and each faculty will have to consider how to best enhance their students' appreciation and knowledge of the following areas.

It will be imperative for students to gain a historical perspective of the development of citizen participation. This is particularly important inasmuch as the level and nature of the participation that professionals and organizations encourage will depend on the participants, governmental demands, and many factors that currently remain unidentified.

A major conceptual area requiring intellectual consideration involves the reasons for developing and encouraging citizen participation. Certain rationales will be obvious, such as the rights of citizens to influence institutions that affect their lives and well-being, and the desire of social welfare organizations to mobilize untapped resources and knowledge and to increase the community's utilization and awareness of the services they seek to provide. Students will have to learn to appreciate the potential use of citizen participation as a mechanism to focus service delivery on culturally and socially determined needs, as a force to enhance professional and organizational accountability and to influence social change, and as a sociotherapeutic effort to cope with alienation and powerlessness in minority communities.

The ways in which citizens participate will require some attention within the curriculum. The objective here would be to acquaint students with long-established methods of involving citizens as members of advisory/decision-making boards and as volunteers, and with the newly emerging formats such as lay spokespersons or paid representatives of the community (e.g., paid indigenous workers as paraprofessionals), and as advocates and contributors in public forums and hearings. Innovative formats to involve citizens that are still being developed should be identified as the future professional contributions of current students and newly trained workers.

Undoubtedly, students will need to be exposed to some of the problematic issues related to the process and goal of citizen participation. The literature is replete with examples of the difficulties professionals have in choosing and establishing appropriate community representation; the differences between organizations and citizens regarding goals, processes and priorities; and the impact of class, racial, and cultural differences between professionals and citizen participants. Similarly, acknowledgement will need to be made of the disruptive methods that some participants have utilized, coupled with the crisis approach to citizen participation that professionals have tended to adopt. Currently we are beginning to appreciate another key variable, namely, the response patterns of staff and administration to citizens' demands to participate. Tischler has provided an interesting paradigm developed from observing a crucial situation. Obviously this paradigm will have to be assessed for its generalizability to other situations, but it should enable students to gain some needed understanding.[10]

The ultimate goal of incorporating any content on citizen participation within the social work education curriculum will be to develop the behavioral skills of professionals in developing and increasing relevant consumer participation. It has been suggested above that some of the requisite knowledge and skills are currently within our professional repertoire. Thus what is now required is to enhance students' awareness of their professional responsibilities relative to citizen participation. These responsibilities include identifying, recruiting, and involving participants; training participants for effective functioning; providing information on existing community resources and developing needed community resources; and clarifying the authority and responsibility of citizen participants. As the process of participation evolves, social workers will need to assume some responsibility for the development of leadership and skills in disadvantaged communities and to assist in the implementation of objectives on which organizations and citizen representatives mutually agree.

As an emerging conceptual and practice area, citizen participation should benefit from detailed and systematic evaluation. Students should be encouraged to develop mechanisms for assessing who participates and how effectively, and how participation is induced, maintained, and utilized by professionals and organizations. Ultimately it will be extremely important to document the impact of citizen participation on the organization, the participating citizens, and their respective communities.

The applicability of much of what we currently know is clearly evident in the curriculum model suggested above and those proposed by Kane for developing a rationale and genuine organizational approach to citizen participation, and by Robins and Blackburn for increasing the competence of citizens to participate more cogently.[11]

A careful review of these models reveals that the following well-known concepts and principles would inform and energize the process. From work with individuals we could draw on insights clarifying individual motivations and worker's activities to achieve purposeful linkages with social systems. The principles in work with groups dealing with encouraging mutual aid between members, the elements of group membership and formation, the identification and achievement of group and individual goals and methods to maintain investment and participation, all would be instructive. Without doubt our experiences in organizing communities, bargaining and negotiation, and identifying accomplishable goals would be relevant to the processes of citizen participation. The elements of administrative know-how that speak to needs assessment leading to an organization plan, the sharing of power, and the willingness of individuals to support decisions in which they have participated are uniquely informative. The developing skills in social work consultation and mental health education, such as gaining entry into systems, focusing on the consultee's strengths and goals, and helping people identify and utilize resources relevant to their goals appear to be natural contributions to any effort to work with citizen particpants.

The observations presented here are merely suggestive and are by no means exhaustive. Further, extensive curricular efforts are needed to document how much and in what ways our current knowledge and skills apply to the process of developing and utilizing citizen participation. Similarly, research efforts to develop and test hypotheses and to provide greater clarity as to what we mean by citizen participation, what we do to induce and implement the process, and especially how we do it, are immediate prerequisites.

As practice and theory developments occur, a substantive issue requiring attention will be the community to which major consideration is given. Practitioners will find it most comfortable to relate to middle-class groups and the dominant ethnic community. However, those responsible for the development of governmental regulations envisioned that the poor and minority communities would be the target population, and the implications for those groups are at once critical and the source of confusion.[12]

Special Implications for Minority Groups

In her recent book, *Black Empowerment: Social Work in Oppressed Communities,* Barbara Solomon observed:

> The theme of powerlessness among minority groups in the United States is a constant ringing in the ear of the nation. Certainly, it has been identified as a predominant consequence of the black experience. Powerlessness of black individuals, groups and communities arise through a process whereby valued identities and roles on the one hand and valuable resources on the other are denied, all of which are prerequisites to the exercise of interpersonal influence and effective social functioning.[13]

Since the 1960s, the movement of all minority citizens—black, brown and red—toward self-determination and the management of their own destinies has accelerated dramatically. No longer are they willing to allow professionals and politicians to single-handedly define problems, propose solutions, and implement programs ostensibly because they know best or are in control of the resources. Members of minority communities have assumed correctly that having a voice in the way institutions minister to their needs will counteract the longstanding powerlessness and sense of alienation and ineffective social functioning that it generates. Thus citizen participation is a special form of the more general thrust by previously excluded citizens toward becoming a viable force in the sociopolitical life of this nation.

It is clear that the tide cannot be stayed, even if someone wanted to do so. A recent survey by The National Council of Community Mental Health Centers reported that community boards in three-fourths of existing community mental health centers had either complete or substantial control over the center's operations. Unfortunately, the report also noted that membership on these boards continued to be overwhelmingly representative of traditional community power structures.[14] It is inconceivable that this situation can continue in this manner, given the increasing demands of minority groups, their success in certain strategic centers, and their increasing support through federal legislation.

Citizen participation as a process offers hope to minority groups at a time when they are beginning to despair about whether desirable social changes will ever occur. Purposeful implementation and institutionalization of this process would have unprecedented benefits both to the professional social worker and the communities involved. On the other hand, continuing organizational resistance to change and to the sharing of power will force minority communities to resort again to protest and disruption. Social work and the mental health professions currently have an opportunity to be truly responsive to the interests and needs of those whom they serve. Enhancing greater participation of such minority citizens would represent a radical social change equal to the bold new approach of community mental health.

NOTES

1. Nicholas Hobbs, "Mental Health's Third Revolution," *American Journal of Orthopsychiatry*, Vol. 34 (October 1964), pp. 822-833.

2. Ruth B. Caplan, *Psychiatry and Community in Nineteenth Century America* (New York: Basic Books, 1969).

3. *Ibid.*, p. 39.

4. Clifford Beers, *A Mind That Found Itself* (New York: Longmans, Green and Co., 1908).

5. U. S. Department of Health, Education, and Welfare, *Regulations: Title P. L. 94-63, Federal Register* (July 30, 1975).

6. Richard Cloward and Irwin Epstein, "Private Social Welfare Disenchantment from the Poor," in *Social Welfare Institutions*, ed. Mayer Zald (New York: John Wiley, 1965).

7. See for example, William M. Bolman, "Community Control of the Community Mental Health Centers: I. Introduction," *American Journal of Psychiatry*, Vol. 129 (August 1972), pp. 173-80; and Gary L. Tischler, "The Effects of Consumer Control on the Delivery of Services," *American Journal of Orthopsychiatry*, Vol. 41 (April 1971), pp. 501-505.

8. "Position Statement on Community Mental Health," mimeographed (New York: National Association of Social Workers, 1968).

9. See for example, Seymour R. Kaplan and Melvin Romais, *The Organization and Delivery of Mental Health Services in the Ghetto: The Lincoln Hospital Experience* (New York: Praeger, 1973); and Abraham Lurie and Gary Rosenberg, "Problems in Community Organization for Mental Health," *Hospital and Community Psychiatry*, Vol. 23 (November, 1972), pp. 350-53.

10. Tischler, *op. cit.*

11. Thomas L. Kane, "Citizen Participation in Decision-Making: Myth or Strategy," *Administration in Mental Health* (Spring 1975), pp. 29-34; and Arthur Robins and Cheryl Blackburn, "Governing Boards in Mental Health: Roles and Training Needs," *Administration in Mental Health* (Summer 1974), pp. 28-36.

12. Daniel L. Moynihan, *Maximum Feasible Misunderstanding* (New York: Free Press, 1969).

13. Barbara B. Solomon, *Black Empowerment: Social Work in Oppressed Communities* (New York: Columbia University Press, 1976), pp. 11-12.

14. *Report on Community Participation* (Washington, D. C.: National Council on Community Mental Health Centers, 1974).

VII

Primary Prevention in Community Mental Health: Holy Grail or Empty Vessel?

BY HELEN REINHERZ

This chapter[1] will present origins of the powerful but controversial idea of primary prevention and its application for social work practice and education by tracing the definition of the concept from its beginning in public health theory. The current state of social work knowledge and practice in primary prevention will be described. Specialized skills utilized in preventive programs including consultation, education, and utilization of networks of familial and community resources will be highlighted. The implication of these programs for vulnerable groups, including children and minority groups, will be presented. Finally, specific recommendations will be made for social work practice and education.

Primary Prevention: Its Proponents and Critics

There are few concepts and approaches in community mental health that continue to be, simultaneously, so criticized and lauded as primary prevention.[2] The elegance of the idea espoused by community mental health theoreticians and the appeal to parsimony of "an ounce of prevention" has led many respected professionals to hail "Primary

Prevention: An Idea Whose Time Has Come."[3] The report of the President's Commission on Mental Health has made prevention, particularly of developmental and mental health problems of children, one of its major priorities.[4]

On the other hand, some have argued that primary prevention programs proceed on unproven assumptions, encourage unfulfilled expectations, and divert energy and resources from the care of the seriously mentally ill.[5] Other difficulties of primary prevention include administrative problems arising from conflict of medical (treatment) goals and health (prevention) goals.[6] Bloom[7] and Munoz[8] stressed the need for establishing a firm empirical data base, only now being developed for preventive programs. Sanford, inquiring about the very necessity of the concept, stressed the need for enhancement of personality development through the life cycle—rather than prevention of pathology.[9] Baxter[10] and Crowell[11] raised practical questions and gave only a few clues to payment for costs of primary prevention when reimbursement is usually received through payment for treatment.

The difficulty of translating the abstraction "primary prevention" into reality is illustrated by images presented by major prevention advocates. Kessler and Albee likened the field to the Okefenokee Swamp, luring the unwary with apparent solidity and beauty, but full of dangers and pitfalls.[12] Bloom suggested a theoretical action model for primary prevention based on medieval "miasma" theory, whereby broad-scale sanitation programs eliminated disease in spite of incorrect assumptions of causation.[13]

Most striking is the power of the idea to sustain its advocates, in view of the fact that in national studies community mental health center staff have spent on the average about 6.6 percent of their time in preventive activities.[14] Innovative approaches and carefully evaluated programs have been slow in developing in this area of community mental health, according to Cowen, a major theorist in the field.[15] Next, as an approach to understanding, we shall turn to an examination of the concept itself.

The Origin of the Concept

Although there are many possible disagreements among experts in discussing primary prevention,[16] there is clear unanimity that the conceptual framework originated in the field of public health.[17] In public health theory, *prevention* can cover all efforts to deal with illness in humankind. Primary prevention refers to activities undertaken prior to the onset of disease, with the goal of avoiding its occurrence and building resistance in a potentially vulnerable population—often called "population at risk." Examples in public health include mass innoculation against smallpox. Primary prevention also can include the promotion of positive health by promoting healthy life styles.

Secondary prevention in public health consists of early diagnosis and treatment for those at the early stages of illness. Screening programs for a variety of problems are included under the secondary prevention rubric. Tertiary prevention includes rehabilitative programs aimed at reducing the aftereffects of illness.[18]

Caplan's formulation for the field of mental health of the levels of prevention was operationalized by Perlmutter el al.[19] to differentiate programs in community mental health centers. The levels were described as follows:

> Primary prevention aims at reducing the incidence of new cases of mental disorder in the population by combatting harmful forces which operate in the community and by strengthening the capacity of people to withstand stress.
>
> Secondary prevention aims at reducing the duration of cases of mental disorder which occur in spite of the programs of primary prevention. By shortening the duration of existing cases, the prevalence of mental disorder in the community is reduced . . .
>
> Tertiary prevention aims at reducing the community rate of residual defect which is a sequel to mental disorder. It seeks to ensure that people who have recovered from mental disorder will be hampered as little as possible by their past difficulties in returning to full participation in the occupational and social life of the community.[20]

Among recent authors in the field, more stringent rules are being applied to both terminology and methodology. Cowen[21] and Goldston suggested that the term "prevention" should refer to "primary prevention" alone. Goldston recommended that primary prevention applies only to programs that are addressed to "specific populations for specific purposes."[22] Goldston believes in rigorous evaluation of all primary prevention activities. Thus the question still remains as to why, in spite of considerable problems in both conceptual clarity, programmatic actualization, and documented evaluation, adherents of primary prevention—including social work advocates such as Wittman, Meyer,[23] and the author of this chapter—continue to espouse its cause. The remainder of the chapter will address this question.

Prevention's Conceptual Framework and Social Work

From the days of Jane Addams and Mary Richmond to the present time, the social work profession has been concerned with humane policies that strive to prevent social dysfunction.[24] In *Preventive Intervention in Social Work,* Meyer noted the attraction of the concept for social workers, who, more than other professional groups, have stressed the relationships and connections between social structures, the environment, and the individual. Meyer saw social work's preventive role actualized through several avenues of activity: consultation to primary institutions in society, family life educational programs, and monitoring of social policies and their impact on human functioning. Further, Meyer linked the requirements of preventive intervention with the worker's active use of clients' strengths, always with the goal of restoring or improving the balance between the client and the client's environment.[25]

Current Participation of Social Workers in Primary Prevention Programs

Despite the close kinship of social work's values and skills and those of primary prevention, there is a surprising paucity of social workers' time and involvement expended in community mental health programs of primary prevention. In part, this is reflective of the major investment of all mental health professionals in treatment and rehabilitation.[26]

Several studies have addressed the actual time that social workers have expended in specified activities in mental health settings. Not one of 73 social workers from representative mental health agencies in Wisconsin mentioned consultation or education as being among the services that they provided.[27]

Berg, Cohen, and Reid studied 377 social workers in 19 community mental health facilities in Chicago and New York. Although workers in community mental health oriented agencies spent as much as 20 percent of their time on prevention, workers in more traditionally oriented settings spent only 5 percent of their time in similar activities.[28]

A Council on Social Work Education report on community mental health practice in nine communities noted much less stress on social work prevention functions than in direct treatment programs.[29] However, in a comparative study of curriculum of schools of social work covering the same communities, schools reported considerable content in primary prevention, crisis intervention, and consultation and education. Each of these content areas was reported at the mean or above of *all* mental health content taught in surveyed schools.[30] These findings may be interpreted pessimistically as another example of lack of "goodness of fit" between education and practice or they may be presented optimistically as auguring well for future expanded practice of primary prevention by social workers who have early exposure to principles of preventive work.

Contributions of Social Workers to Primary Prevention Programs

An extensive survey of the literature on prevention clearly revealed some outstanding contributions from the social work profession. Beginning in the 1960s, Parad wrote extensively about innovative programs in crisis intervention.[31] Silverman's Widow-to-Widow program is widely cited.[32] The research of Perlmutter in defining programs of prevention has appeared in many interdisciplinary journals.[33] Innovative programs utilizing natural support systems have been developed by Collins and Pancoast. Collins' work with "natural networks" of neighbors is one of several promising new approaches.[34] The work of social agencies in developing programs and strategies for family life education has furnished the base for many programs designed to increase coping capacity and promote positive mental health.[35]

Classification of Programs for Primary Prevention

As Perlmutter has indicated, programs in primary prevention can be classified along a number of dimensions. The most parsimonious definition of preventive programming comes from the definition of primary prevention: (1) activities to promote mental health and (2) activities to reduce the incidence of emotional disorders.[36]

Lydia Rapoport, a prophetic woman, divided primary prevention activities into three types. First was the promotion of "well-being" by the strengthening of coping and problem-solving activities through education and "anticipatory guidance" for events such as marriage and parenting. Second were "specific protection" activities designed to prevent disabling sequelae for those exposed to traumatic events. Third, she listed preventive activities aimed at combatting destructive social policies that undermined coping capacities and autonomy.[37]

Vayda and Perlmutter, in a more recent article, divided primary prevention programs into "institutional" level intervention, including program consultation and training of community "care takers," and "individual" programs for vulnerable groups facing developmental and situational crises.[38]

Programs Aimed at Reducing the Incidence of Emotional Disorders

These programs fall under Rapoport's definition of "specific protection" and Vayda and Perlmutter's classification of "individual" intervention.[39] Most of the programs in this category are based on crisis theory, one of the cornerstones of community mental health theory and practice.[40] Quoting Caplan and Lindemann, Rapoport defined a crisis as "the state of the reacting individual who finds himself in a hazardous situation."[41] Some events, such as the loss of a spouse through death, are expected to have universal impact. There also are situational crises such as traumatic natural events: war, floods, and other personal disasters, including loss of employment. Important developmental (life cycle) crises include school entry, adolescence, and marriage. All crises present opportunities for growth or regression—

possibly resulting in mental illness.

Specific approaches for reducing the incidence of emotional disorders in vulnerable at-risk groups include programs for adolescent mothers and fathers.[42] Other vulnerable groups include young professionals exposed to unusual professional stress,[43] and groups such as homosexuals who suffer from societal discrimination.[44] At-risk populations encompass those experiencing major natural disasters such as earthquakes.[45] Preventive programs also have been established to help rape victims cope with their experience.[46]

Support groups may be created specifically to provide help to prevent the onset of serious sequelae of major traumas. The Widow-to-Widow Program established in Boston offered a mutual support group to help the recently bereaved cope with grief and loss.[47] Programs also have been established to aid in adjustment of infertile couples.[48] Another group, currently the focus of much interest, consists of families experiencing loss due to sudden infant death syndrome.[49] Early crisis intervention includes information and support for both parents and surviving children in coping with death and its aftermath.

Programs Promoting Positive Mental Health And Enhancing Competency

Health promotion is a major thrust of current planning for health and also is a major new emphasis in mental health.[50] Recently a number of approaches have received renewed emphasis, including "anticipatory guidance" of individuals undergoing role transitions or change in status.[51] Another important emergent approach mentioned earlier strengthens interconnecting "natural networks" and, if needed, develops "artificial networks" to offer support for individual functioning.[52]

Hollister proposed "stress resistance building" as a major approach to primary prevention.[53] Programs in this category provide strength-building experiences (strens) through educational programs for clearly specified target populations such as new parents[54] or preretirees.[55]

The President's Commission on Mental Health, along with many other people in the field, has identified young children and their families as a major target group for primary prevention activities.[56] The report of the President's Commission highlighted pregnancy and the perinatal period as a time for providing total health care both for the mother and the developing infant. It is a time as well for building parenting skills.[57] My own research over the past decade, in which children with major adjustment problems were identified after problems had escalated and were entrenched, underscores this need.[58]

Toddlers' preschools have been initiated in some target neighborhoods, providing group experiences for children as well as participation by parents. Parents' early involvement in children's learning can enhance a child's competence and provide support for later school achievement, which is an important component in child mental health.[59]

One of the earliest approaches to parent-child mental health promotion, begun in St. Louis in 1953, was evaluated in 1973. Parents involved in mental health discussion groups reported significantly fewer behavioral problems over a 30-month period than parents not receiving such services.[60] Social adjustment skills can be taught to children, and mastery of problem-solving techniques have been found to be beneficial in later adjustment of children.[61] Programs to aid parents in promoting healthy emotional development of their children are increasing.[62]

The building of competency in adults has been approached from a variety of perspectives, including marital enrichment programs.[63] Participation of citizens in community projects has long been an established goal of community programs in which "helpers" as well as "helpees" develop increased competency.[64]

Other emerging programs of health promotion, representing models adaptable for social workers, include a high school program to enhance self-image, based on cultural strengths, for Asian-American youth,[65] and a women's liberation group in which a mental health professional served as a consultant.[66]

The Utilization of Natural and Artificial Support Systems

This model of primary prevention has been described by Caplan, Collins, and Collins and Pancoast.[67] It encompasses goals of prevention of disability and health promotion. The method has potential in simultaneously building on the inherent strengths that exist in natural social networks in which people function. Through planning, the expertise of the mental health consultant serving several large networks may be extended geometrically.

Collins and Pancoast presented the prototype of a natural network of individuals with considerable influence and knowledge of a neighborhood where home day-care facilities were being developed. The "natural neighbor" provided support and consultation to day-care providers, but also was aware of crisis situations when children were in danger.[68]

Self-help groups providing mutual aid are well-known to all mental health workers. At times, however, mutual aid networks may be artificially created by professionals who act as consultants and catalysts rather than as direct givers of service.[69] Baker addressed the complementary nature and balance between the professional and the natural support system.[70]

The programs of (1) preventing disability and (2) promoting positive mental health require some specific skills. Many of the programs described require skill in consultation, education, and promotion of organizational and institutional change. The next section will discuss these skills, as well as the preparation for their use in community mental health programs by social workers.

Creating Skills to Carry Out Programs—Implications for Social Work Practice and Education

Consultation

Consultation continues to be one of the most prominent modalities associated with primary prevention.[71] The place of consultation in social work, from the beginning of the profession to the current time, has been well-delineated in Kadushin's recent book.[72] Consultation is a process in which one professional person employs expertise to help another carry out work responsibilities more effectively. Part of the impetus for consultation in the past two decades has come from additional need for professionally trained mental health manpower. Through consultation, the limited supply of highly trained personnel can reach less-trained caretakers such as clergy, teachers, and family doctors who serve as therapeutic agents for many people.[73] Recently, consultation has been given to less traditional caretakers such as neighborhood workers, bartenders, hairdressers, and others without professional training. Social workers—by far of all mental health professionals—give the greatest amount of consultative service, according to Kadushin. In 1974, 25.6 percent of consultation time in community mental health centers was provided by social workers, as compared to 5.5 percent by psychiatrists.[74]

In an extensive literature review, Carter and Cazares concluded that the mental health field, building on the original Caplan model,[75] has expanded the model "to include applications of learning theory and practice of consultative intervention on the administrative and social systems level."[76] Thus, in spite of the passage of time and some variations,[77] Caplan's conceptualizations continue to form the theoretical framework for the practice of consultation.[78]

Caplan defined mental health consultation as "interaction between two professional persons, the consultant, who is a specialist, and the consultee, who involves the consultant's help in regard to current work problems with which he is having some difficulty and which he has decided are within the other's area of specialized competence."[79] Caplan's model, which is fully explicated in his writings, encompassed two basic types of consultation: "case" and "administrative." Within these types there were several variations. Most controversial in both major groups was consultee-centered consultation where the consultee was viewed as a target of change rather than the client or program. However, all of Caplan's original formulations continue to be utilized by most mental health consultants.[80]

Although most social work consultants in community mental health report case consultation as the most frequent type offered, an increasing number also report use of administrative program consultation, since it affords opportunities for system changes affecting large numbers of clients. With further thrusts toward community-based services,[81] this modality certainly will continue as an increasing responsibility of social workers who historically have bridged and facilitated the interactions between institutional structures and individuals.

Techniques for Enhancing Competencies: Educational Programs and Commmunity Development Approaches

Under the combined rubric of education and community development, some exciting approaches to prevention are being launched. Consultation often is used in combination with either educational or community development in a single preventive program emanating from community mental health centers.[82] In a program developed by Kellam et al., the target population chosen by the community was children entering school. The program included direct work with the first graders of some schools in order to expedite transition to the status of "pupil." It also included training teachers to work with their classes in aiding children to develop coping capacities.[83]

Among the techniques utilized to promote positive growth and development of children was the use of role modeling and training in an educative role for the parents of young children. Berlin described this technique for affective development, and Spivack and Shure for cognitive as well as general competency growth.[84]

A variety of educational programs fostering competency that was focused on various target groups were described earlier. However, there have been few systematic approaches outside of agency in-service training to prepare for professional leadership in such programs. At the Simmons College School of Social Work, a course was developed in 1976 by Priscilla Riley entitled "Educational Methods of Prevention" in the school's Community Mental Health Training Program that was structured to prepare students to plan and implement preventive programs. Programs have been designed and implemented by students for parents of infants, single-parent groups, and adolescents.

Community-development and leadership-development programs recently have received added attention in promotion of positive mental health. These programs have potential not only for aiding the communities involved, but also the community members who participate.[85]

Such a program in rural Kansas was described by Raber, a social worker who involved the town "influentials" in leadership training, which resulted in a great deal of forward movement.[86]

Implications of Preventive Mental Health Programs for Minorities and Other Vulnerable Groups

A number of the approaches already discussed presented goals and methods appropriate to the needs of inner-city and minority groups utilizing the strengths of the community to plan intervention around identified needs.[87] Leutz, in a study of East Harlem, identified the efficacy of work with informal community care givers in planning programs to combat drug abuse.[88]

One of the major target groups in our society is children, who ideally should be reached during early infancy. However, children often are accessible to identification and intervention only at the time of school entry.[89] Nir has highlighted the importance of administrative program consultation in poverty-area schools where environments must be changed to meet developmental needs of children.[90] Townsel, Irving, and Stroo developed mobile consultative and educational services to meet the needs of children located in a variety of sites in an inner-city area. Services provided included consultation and support to individuals in the community who could act as resources and helpers for others.[91] Prunty, Singer, and Thomas evolved a mental health consultation program specifically to combat racism in newly integrated city schools. Eighty percent of the school faculty found the consultation helpful in promoting communication and sharing among staff members.[92]

Although, in general, programs designed to reach ethnic minorities, the poor, the aged, and other vulnerable groups have focused on specific direct service needs,[93] there are some promising beginnings, particularly in programming for children. Programs building on strengths inherent in cultural and ethnic diversity should be encouraged.[94]

Summary and Implications of Primary Prevention For Social Work and Social Work Education

This chapter began with the question of whether *primary prevention* was the long sought after "holy grail," which would provide the key to avoiding mental illness for many and would promote enhanced positive mental health for all. As a confirmed believer in the continued potential of prevention, this writer is encouraged by the emergence of new technologies that are beginning to evolve, particularly in the field of social work, which has a historic commitment to the identification and utilization of client and community strengths. In spite of few examples of hard empirical validation, we grail-seekers continue to view the goals of promotion of health and prevention of illness as a first line in the fight for true community mental health.

Increased interest in the advancement of primary prevention programs in social work was evidenced by a special panel presentation at the 1978 Annual Program Meeting of the Council on Social Work Education, which was devoted to research and education in primary prevention. The existence of courses entitled "Building Natural Support Systems" and "Educational Methods of Prevention" lend credibility and support to a greater investment of the profession in this direction. In addition, a number of schools have developed integrated training programs within the conceptual framework of prevention.

For the future, social work education needs to enlarge its educational offerings, particularly in the area of teaching technical competence for programs of health promotion. Practice, also, must continue to develop and empirically evaluate new preventive programs, as well as continue to develop, build on, and utilize older techniques such as mental health consultation. Specialists in primary prevention in social work should emerge as a result of the renewed thrust and opportunities that would be developed.

Thus, although the cup of primary prevention may not provide a draught of universal panacea for all mental health problems, it is not solely filled with empty promises. Primary prevention deserves to be included in the future education and practice of social work in community mental health.

NOTES

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VIII

Deinstitutionalization and The Chronic Mental Patient

BY MAX SILVERSTEIN

As a result of deinstitutionalization programs, the problems associated with the care of chronic mental patients constitute a national crisis. This was a major finding of a Conference on the Chronic Mental Patient held in January 1978, sponsored by the American Psychiatric Association in collaboration with the President's Commission on Mental Health.[1]

It is estimated that over one million Americans suffer some form of chronic mental disorder. All indicators point to a rise in those high-risk populations, particularly the elderly, that generate chronic mental patients.This is not a crisis that will fade with time, rather, it will intensify unless steps are taken to deal with it.

Social workers can play a vital part in the action to overcome the crisis. Perhaps more than any of the mental health professionals, social workers have been at the heart of the deinstitutionalization process, from discharge planning to involvement in the struggle for comprehensive community support systems of care for the mentally ill. Social workers have first-hand knowledge of the devastating effects of the persistent, recurrent episodes characteristic of chronic mental patients in the community. They also sense that the chronic mental patient once again has become the outcast, the rejected one, in the "bold new approach" of the mental health care system.

This chapter outlines the nature and genesis of the crisis, suggests initial steps to deal with it, and identifies professional responsibilities of social work practitioners and educators in the processes of change for a more effective, comprehensive mental health program.

Genesis of a Crisis

Programs for the care and treatment of the mentally ill have undergone decisive changes. The changes started with the passage in 1947 of the National Mental Health Act, which gave the federal government direct responsibility for assistance in research, training, and services in mental health. The discovery and use of psychotropic drugs, the 1955 Joint Congressional Resolution creating the Joint Commission on Mental Illness and Health and its report, *Action for Mental Health,*[2] the "bold, new approach" of the Mental Health Centers Act of 1963, and a series of court decisions establishing patients' rights, including the right to treatment, are benchmarks of these changes. The impact of these developments has been considerable. Between 1955 and 1975, populations of state and county mental hospitals declined from 559,000 to 195,000, and are continuing to decline at a steady rate.[3]

The concept of deinstitutionalization of the mentally ill was at the heart of these efforts. Most investigators and responsible leaders, in viewing deinstitutionalization, included the stricture that not *all* mental patients *at all times* could be treated effectively without hospitalization. It was inevitable that many public officials overlooked this major condition of deinstitutionalization in an undifferentiated way to mean "get them *all* out; we don't need these human warehouses."

In this departure from past practice, two factors are crucial. First, to speak of the hospitalized mentally ill as a body, with similar or even related needs, is misleading. Public mental health hospitals have been the only available resource for the chronically ill, the seriously disabled, and the severely handicapped mentally ill patient. They constitute a sizeable proportion of the hospital caseload. It is estimated that between 20 and 30 percent of mental patients will require sustained hospitalization or periodic stays. Even among those for whom institutionalization is judged to be inappropriate, many are so diminished in capacity that they cannot maintain themselves independently in the community. They stand in need of appropriate alternatives, particularly in the form of residential settings in which personal restorative services are available. Attempts to provide enough settings for this purpose through halfway house and foster care programs have fallen short. The task of increasing the number of foster homes and halfway houses to the level required for tens of thousands of prospective clients is monumental. Furthermore, many of the recently developed community-based programs are not geared to serve the chronically and severely disabled, nor do they evidence strong interest in undertaking to do so.

One outgrowth of this situation is that tens of thousands of disabled individuals reside in largely unregulated boarding homes. Evidence as to the effectiveness of even the more adequate of such settings in caring for the chronic patient is often indecisive, but there has been enough evidence of poor quality care—sometimes extending to exploitation and abuse of residents—to alarm many human service professionals and public officials. The report of the Senate Subcommittee on Long-Term Care, for example, described substantial and widespread abuses in boarding homes in four states and the District of Columbia, stating that these were representative of national conditions.[4]

Overall, there is increasing evidence that public officials, in their haste to economize and to shed basic public responsibility for the mentally disabled, have created chaotic and sometimes scandalous conditions in communities to which patients have been discharged. Premature, unplanned discharge practices have created the inevitable communinity backlash. The whole scheme of deinstitutionalization of the mentally ill rests on a supportive community-sponsored network of services. Without this network, deinstitutionalization is programmed for failure.[5]

The economics of institutional care have changed substantially. Upgraded accreditation standards for mental hospitals, coupled with spiraling inflation, have prompted the hope that less expensive care alternatives can be found within the community. Judicial decisions defining a "right to treatment in the least restrictive setting possible," while narrowing the grounds for involuntary commitment, also auger the intensified need for the development of community services.

For some mentally ill, changing policies have meant that the state hospitals—once home and haven—can no longer be relied on to open their doors in times of stress.

Although deinstitutionalization focuses immediately upon community-based service, the long-range view must take into account the continuing and projected growing need for appropriate institutions for the seriously disabled, chronic mental patient. While the population of mental hospitals was decreasing, the population of other institutions was growing. For example, long-term, chronic patients, who, prior to the community mental health center programs were directed to state hospitals, were being diverted to nursing homes. In 1950, the rate per 100,000 population was slightly over 400 in mental hospitals; in 1970 it was slightly over 200. During the same period the change in rate for homes for the aged and dependent was in the reverse direction: the 1950 rate was 200, the 1970 rate was 450. It can be assumed that a sizeable proportion of the chronic mentally ill who were thought to be deinstitutionalized were merely shifted from one institution to another. Whether the shift in all cases was in the interest of the patient is a matter of considerable doubt.[6]

It should be noted that many nursing homes provide adequate care; in most, conditions are tolerable. However, many chronic patients without resources or family find themselves, after hospital discharge, drifting into substandard, overcrowded, filthy, isolated "rooms" in the inner-city. Judge David Bazelon, a long-time advocate of the mentally ill, observing the deinstitutionalization phenomenon, warned that back alleys are no better than back wards.

Population changes projected by the Census Bureau and analyzed by NIMH should give pause to those who seek to phase out or close down mental hospitals. This analysis projects a U.S. population increase of almost 20 percent by 1985 and includes an increase in the 25-34 age group of approximately 60 percent for whites and 80 percent for nonwhites. If the same level of services is maintained for this age group in 1985 as existed in 1970, there will be a 63 percent increase in the number of mental health care episodes. If the 1970 incidence rate is the same in 1985, the number of new cases per year of schizophrenia and manic depressive reaction (affective disorders) in the vulnerable age bracket will be 60 to 70 percent higher.[7]

Clearly, the overall percent increase in numbers of new cases of schizophrenia is predicted to exceed the overall percent in general population increase. Not only will the number of mentally ill increase, but the duration of their illnesses also will be longer according to these estimates.

As compared to the general population, the mentally ill have a higher death rate. However, there is a trend toward a notable reduction in this figure as a result of better care, more rigorous public health and sanitary provisions in mental hospitals, and so on. Aged persons, some of whom suffer from senile brain disorder, cerebral arteriosclerosis and a variety of mental and emotional distresses sometimes associated with advanced age, generally are living longer.

All in all, it is expected that the survival rate of the mentally ill will increase, thus increasing their total numbers, particularly of those who are most vulnerable to disabling psychoses and chronic disorders.[8] It is precisely this population that may require good hospital care. Any indecent haste toward closure could lead to a social disaster in the near future.

The Rejection Syndrome

The stigma of mental illness and its consequences in social attitudes and social practices are well known. They are still persistent and most pronounced with regard to chronic mental patients who traditionally have been "lumped" and "dumped." Lumping is a convenient way of stereotyping; dumping is a logical outcome of stereotyping. They work in tandem: the lumping of all hospitalized mental patients as proper candidates for community living; the dumping of as many patients as possible into communities without provision of the vital support systems in place.

The leitmotif of chronicity is that of hopelessness. This mood pervades the professional as well as the lay community. In the past, chronic patients were relegated to back wards in state hospitals—out of sight, out of mind. In today's more "advanced" programs, they are to a large extent shunted to one side into boarding or nursing homes, while the so-called "active caseload" is treated in community mental health programs of various kinds.

The fact is, that with modern therapies, many "hopeless" chronic patients have done as well as many of the acutely ill. These therapies include medical, psychiatric, social, and rehabilitative efforts in proper combination. Mental health professionals who have been able to overcome their own rejection of the chronic patient have demonstrated the effectiveness of these active therapeutic and social interventions. The past tendency of psychotherapists to evade the typical chronic patient may be weakening. They have learned that psychotherapy, combined with sound social and community services, can be useful to patients who are not necessarily "highly motivated, reflective, with high degrees of personality organization, experiencing acute discomfort, and able to express emotion."

The term "chronic mental patient" itself stigmatizes the people concerned and obscures their diversity and potential for change. This is not to underestimate the unique problems of the chronic patient: high vulnerability to stress, extreme dependency needs, difficulties in coping with everyday living demands, vocational, income maintenance, housing, and interpersonal skills' deficits, to name the more obvious ones.

Programs that deal successfully with chronic mental patients are based on certain minimal criteria. They provide a variety of residential and nonresidential services on a continuum to insure that care is tailored to meet *individual* needs. They offer easy access to all mental health services and ready reentry into the system at all points. They are geared to be responsive to crises, and employ a wide variety of professional and nonprofessional personnel who have an interest in, knowledge about, experience with, and skill in the treatment of the chronic mental patient, the family of the patient, and the community in which the patient lives. All three—the patient, family, and community—are actively engaged in the treatment process. The major goal is an ever-increasing degree of self-sufficiency and independence for the patient, developed within a sustained community support system of people and services.

The Conference on the Chronic Mental Patient cited these obstacles to effective delivery of services to the chronically mentally ill: the attitudes of patients, families, communities, professionals, and community leaders; the lack of an integrated community support system; fragmentation of federal programs; the absence of unified funding; the failure to designate responsibility for treatment, care, and rehabilitation of the chronic patient; and widespread discrimination in employment, ambulatory care funding, and zoning restrictions amid conflicting and/or limiting federal and state regulations.[9]

There obviously is a strong interdependence between the mentally ill and the communities to which they return. The best rehabilitative community systems of services will fail in their restorative intentions unless the individual and collective responses of friends, employers, neighbors, and communities create a welcoming and supportive environment. That such an environment does not exist in many places is apparent. Most studies of community careers of former patients indicate severely limited opportunities for them. Discharged patients increasingly report a disturbing degree of rejection and social isolation.

The tragic effects of the rejection syndrome for mentally ill racial minority peoples is that they find themselves in double jeopardy—as an oppressed minority and as mentally ill. The rates of certain illnesses among nonwhites are roughly twice that of whites. With schizophrenia, the incidence rate for whites is 50 per 100,000; for nonwhites it is 118.6. In the affective disorders, among whites the rate is 12.2 per 100,000, while for nonwhites it is 24.4. These disorders breed chronicity.

The community rejection syndrome can be overcome only when hospitalized mental patients are no longer dumped upon unprepared and hostile communities. A first prerequisite is to create and sustain appropriate and adequate community treatment facilities for the mentally ill, particularly for the discharged mental hospital patient. Community attitudes can be modified only within the context of sound programs in which the community has a stake.[10]

Leadership to create such a sound nationwide framework of services rests with public authorities at the federal, state, and local levels who are charged with the responsibility and authority for the public welfare. It should be underscored that this framework must meet head-on the bifocal nature of the current mental health program. It must deal with the apparent confusion of means and ends. Deinstitutionalization conceived as a *means* of achieving a highly desirable *end* is being used or misused as an end in itself. In like manner it must address the either/or fallacies between state hospitals and community services, and the issue of public/private auspices for mental health services.

It is not a choice between providing better state hospitals or more community mental health centers. Each setting has crucial roles to play and functions to perform in a comprehensive and coordinated system of mental health care. One without the other will undermine and eventually cripple both in the long run. If present trends are not reversed, the public mental hospitals will be allowed to deteriorate. Already a large proportion of state mental hospitals—progressively undersupported on the premise of "community" services growth—have lost accreditation because of their inability to meet minimum life-safety standards. This loss of accreditation translates into loss of federal dollars, among other things. This could mean that the unique role that state mental hospitals play in caring for and treating chronic schizophrenics, senile dementia patients, chronic alcoholics, seriously-disturbed, acting-out adolescents, "forensic psychiatric services" for prisoners who are or become mentally ill (and for other categories of patients who cannot be assimilated, treated appropriately, contained, or tolerated in a relatively nonstructured community-based service program) might be forfeited. Without these specialized programs available in the proper setting, the result very easily could be the disruption of the total care and treatment mental health system by overloading the community-based programs with problems they are in no position to handle.

As a beginning point for change, there are certain priority needs to be fulfilled at the national policy level[11]:

1. Active support for the integration and coordination of state (hospitals) and local (community mental health) service programs, with single entering points and continuity of care provisions within the total system of services.
2. Development of national standards, guidelines, and criteria for provision and selection of treatment choices, over the broad spectrum of varied mental illnesses and disorders.
3. Establishing clear division of responsibilities for operating, supervising, funding, and developing community mental health services between federal, state, and local authorities.
4. Assurance of quality care through authoritative public monitoring and licensing systems of community-based psychiatric programs.
5. Creation of a stable financial base (federal, state, local, and voluntary) for the total effort.
6. Assurance that the complex needs of the mentally ill are identified, provided for, and supported adequately in all federal human service programs: for example, social and rehabilitation services, Medicare and Medicaid, SSI, Title XX, HUD, national health insurance, and related programs.

The Context of Change

There is a direct and obvious link between a creative program for the chronic mental patient and the quality of the total system of care for the disabled, the dependent, and the dispossessed. The needs of the chronic mental patient will be met only if the overall mental health program is placed on more solid ground. Likewise, the mental health program itself will prosper to the extent that health, social services, and other related human services programs are effectively supported in public policy and by public action.

Where do we stand? The unhappy fact is that there has been a rising tide against public responsibility for social and health services. It reached new heights during the Nixon administration, as expressed in the philosophy of "benign neglect" and put into practice through impoundment of funds voted and earmarked for public welfare. There are lingering and pervasive ideas in the Carter administration that are not too far removed from those of the previous administration. One of these is the myth that "private" is necessarily better than "public"; that public funds in private hands will yield a more favorable cost-benefit result than a public service. The efforts to phase out public general hospitals as well as state and county mental hospitals are supported by this doctrine. The conflicts around national health insurance are centered on this proposition. While there may be more formal lip service given by this administration to the special needs of the disadvantaged, the presidential phrase, "life is unfair," to rationalize the stand on federal aid for abortions, tells it all.

For social workers there are perhaps no more important issues than those imbedded in the concerted and growing drive to retrench public services in the health and mental health fields. Social workers stand at the major turning points of these issues, which affect their daily practice and challenge their value base and ideology. It is usually the social work staff, for example, that is charged with arranging for alternative care when patients are discharged. When patients are being discharged inappropriately—that is, "dumped"—serious ethical and practice concerns surface. And when these patients find themselves adrift with inadequate or unavailable alternative care, it is the social workers who are held to account for failing to have at hand what has been deemed necessary, but what has not been provided by those responsible.

A truly comprehensive mental health program with its diverse settings could provide the opportunity for social work not only to produce a broad-ranging, useful service, but also to begin to identify and confirm the critical elements in a common conceptual base for social work practice growing out of this experience.

A first step would be agreement by practitioners and educators on the spectrum of professional social work functions required to fulfill the purposes and meet the needs of the mental health clientele, the mental health system, and the broader society we are committed to serve. A second step to be taken jointly would be the definition of the knowledge and skill requirements of each of these functions over the broad reaches of a comprehensive mental health program. The burden then would fall on the schools of social work to design learning experiences that would prepare their graduates to assume the professional responsibilities of these tasks. There would be a further obligation on the schools to insure opportunities for continuing education for all levels of practice in the mental health system. Experience teaches how ever-changing are the characteristics of the tasks social workers are called on to undertake in the volatile mental health enterprise.

It may be hard to find specific curriculum content in many schools of social work that deals fully and precisely with the unique problems of chronic mental patients, despite the fact that "there is no more urgent concern than the needs of the chronic mental patients who suffer from . . . residual social and vocational disabilities," to quote the report of the Conference on the Chronic Mental Patient.[12]

However, it is likely that all curricula address generic problems of long-term care resulting from chronicity and dependency. Highlighting the special problems of chronic mental patients of all ages who may reside in hospitals, in other institutions, or in the community within this general context may be needed to focus the specific content. It also may be difficult to find explicit curricula addressing the collaborative nature of social work practice that unites the concerns of the humanizing effect of social services in restrictive or repressive settings with the mandate to overcome those policies and practices that depersonalize and dehumanize clients.

How these latter activities and clinical practice are interlocked will require special educational and professional attention to decipher. This suggests how necessary it is for mental health practitioners and educators to work together to respond creatively to the needs of the developing mental health program in which the profession has such an enormous stake.

NOTES

1. *Report and Recommendation to the President's Commission on Mental Health* (Washington, D. C.: American Psychiatric Association, 1978).

2. *Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health* (New York: Basic Books, 1961).

3. For a description and analysis of sharp changes in the national mental health picture, see E. L. Bassuk and S. Gerson, "Deinstitutionalization and Mental Health Services," *Scientific American*, Vol. 238 (February 1978).

4. *Report of the Senate Subcommittee on Long-Term Care* (Washington D.C.: U.S. Government Printing Office, 1976).

5. The predicament of the discharged mental hospital patient in the community is vividly described in many professional and popular articles. Among the best are Amitai Etzioni, "No Place to Go," *Washington Monthly*

(December 1976), and *A Report of a Series of Community Meetings* (Philadelphia: Horizon House Institute, 1976).

6. Most of the demographic and related data used throughout this chapter are taken from publications and reports prepared by Morton Kramer, former director of the NIMH Division of Biometry and Epidemiology. Over the years Kramer has been most "on target" of those who study and forecast changes in the mental health needs and services equation.

7. National Institute of Mental Health, *Psychiatric Services and the Changing Institutional Scene, 1950-1985* (Washington D.C.: U.S. Government Printing Office, 1977).

8. *Ibid.*

9. A definitive statement on the chronic mental patient is *Report and Recommendation, op. cit.* This report covers key policy and program issues, including commentary on such concerns as civil rights, administrative reorganization, research and training, funding, community education, and continuity and adequacy of services.

10. Richard Charles Baron, "Community Opposition to the Mentally Ill and the Strategies That Respond" (Paper presented at the Fifth Annual Conference of the International Association of Psycho-Social Rehabilitative Sciences, November 18, 1978).

11. In the fall of 1976, the General Accounting Office (GAO) of the U.S. Congress reported its findings on a study of the effects and effectiveness of the deinstitutionalization effort. The report, *Improvements Needed to Help the Mentally Disabled Return to and Remain in Communities* (Washington, D. C.: U.S. Government Printing Office, 1976), cites the fragmentation and confusion of responsibility among the agencies and institutions serving the mentally ill: "no single focal point has been established at the federal, state, or local levels for developing methods to assure that the mentally ill have access to and receive quality service in appropriate settings." The NIMH and the Public Health Service prepared a careful commentary on the GAO report, and outlined a well-designed program for reform and improvement. A number of these proposals have been incorporated here.

12. *Report and Recommendation, op. cit.*